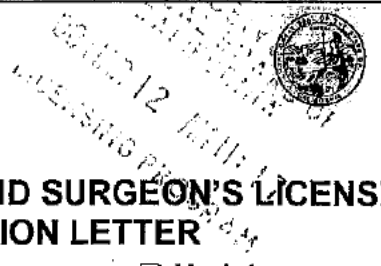
ATS # 213243

STATE OF CALIFORNIA -- STATE AND CONSUMER SERVICES AGENCY

ARNOLD SCHWARZENEGGER, *Governor*

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov



INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☑ **License** ☐ **PTAL** - or - ☐ **Update**

1. NAME : Last: BOULANGER	First: CHRISTINE	Middle: MARIE	MBC Use Only
Other names you have used (include maiden name):	**2. U.S. Social Security Number:** [redacted]		
3. Place of Birth: [redacted]	**4. Date of Birth:** [redacted]		
5. Gender: ☐ Male ☑ Female			
6. Public/Mailing Address: 432 CLAY STREET (Please note: this information is public) (30 characters maximum per line, including spaces) ~~MONTEREY, CA 93940~~			
City: MONTEREY	State/Province: CA	Zip/Postal Code: 93940	Country: USA
7. Telephone Numbers: (include area code)	Home: [redacted]	Work: [redacted]	Cell: —
8. California Driver's License Number (optional): [redacted]	**10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California?** ☑ Yes ☐ No		
9. E-mail Address (optional): [redacted]	Previous license number, if any: G51652		

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance
UNIVERSITY OF VERMONT	BURLINGTON, VT. U.S.A.	9/77 - 6/82
COLLEGE OF MEDICINE		

12. School of Graduation	Degree Awarded	Date of Graduation
"	M.D.	6/1/82 5/22

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)
NBME PARTS 1,2,3	1982	[redacted]

Cashiering Use Only | School Code

L1A

07A-100 (Rev. 12/05)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

14. Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.

Facility Name	Address	Specialty Area	Dates of Attendance
UCLA CENTRE FOR	10833 LE CONTE AVE.	OB/GYN	7/82 - 7/86
HEALTH SCIENCES	LOS ANGELES CA.		

POSTGRADUATE TRAINING (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
CALIFORNIA	G51652	1982-3	1982-1987
MASSACHUSETTS	58266	1987	to present.
NEW HAMPSHIRE	17744	1988	1988-94

APPLICANT: CHRISTINE M. BOULANGER

DATE OF BIRTH: [redacted]

L1B

ABMS CERTIFICATIONS

16. Are you currently certified by a Member Board of the American Board of Medical Specialties? YES ☑ NO ☐

Member Board	Expiration Date	Certificate Number
AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY	VOLUNTARY ANNUAL RECERTIFICATION	

MALPRACTICE HISTORY

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES [redacted] NO [redacted]

PRACTICE IMPAIRMENT OR LIMITATIONS

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES [redacted] NO [redacted]
19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]
20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]
21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]
22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

For each conviction disclosed, you must submit with the application certified copies of the arresting agency report, certified copies of the court documents, and a descriptive explanation of the circumstances surrounding the conviction of disciplinary action (i.e., dates and location of incident and all circumstances surrounding the incident). This letter must accompany the application. If documents were purged by arresting agency and/or court, a letter of explanation from these agencies is required.

Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

APPLICANT: CHRISTINE M. BOULANGER MD

DATE OF BIRTH: [redacted]

L1C

CRIMINAL RECORD HISTORY (cont'd)

24. Is any criminal action pending against you? YES NO

25. Are you required to register as a Sex Offender? YES NO

DISCIPLINARY HISTORY

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES NO

27. Is any denial pending against you? YES NO

28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? YES NO

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES NO

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES NO

31. Have you ever had any license to practice medicine subjected to any other disciplinary action? YES NO

32. Is any disciplinary action pending against any of your licenses to practice medicine? YES NO

33. Have you ever had staff privileges in a hospital terminated, denied, suspended, limited, revoked, or not renewed? YES NO

34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES NO

35. Is any disciplinary action pending against your hospital staff privileges? YES NO

36. Have you ever surrendered a license to practice medicine? YES NO

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES NO

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES NO

APPLICANT: CHRISTINE M. BOULANGER MD

DATE OF BIRTH:

L1D

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, CHRISTINE MARIE BOULANGER MD, [redacted] being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)
oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. CB **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Christine M. Boulanger MD
(Please sign full name)

State of CALIFORNIA

County of MONTEREY

Subscribed and sworn to (or affirmed) before me on

this 10TH day of MARCH, 20 08,

by CHRISTINE M. BOULANGER

~~personally known to me or~~ proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
MARTIN DOOLEY
Commission # 1577029
Notary Public - California
Monterey County
My Comm. Expires May 10, 2009

SIGNATURE OF NOTARY PUBLIC

L1E

07A-100 (Rev. 12/06)

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INITIAL AND UPDATE APPLICATION FOR PHYSICIAN'S AND SURGEON'S LICENSE *OR* POSTGRADUATE TRAINING AUTHORIZATION LETTER

Application for (please check one): ☑ License ☐ PTAL - or - ☐ Update

1. NAME: Last: BOULANGER	First: CHRISTINE	Middle: MARIE	MBC Use Only
Other names you have used (include maiden name):	2. U.S. Social Security Number: [redacted]		
3. Place of Birth: [redacted]	4. Date of Birth: [redacted]		
5. Gender: ☐ Male ☑ Female			
6. Public/Mailing Address: 99 MYRTLE STREET #1 (Please note: this information is public) (30 characters maximum per line, including spaces)			
City: BOSTON	State/Province: MA	Zip/Postal Code: 02114	Country: USA
7. Telephone Numbers: (include area code)	Home: [redacted]	Work: [redacted]	Cell: —
8. California Driver's License Number (optional):	10. Have you ever filed an Application for Physician's and Surgeon's License, or PTAL, in California? ☑ Yes ☐ No		
9. E-mail Address (optional): [redacted]	Previous license number, if any: ~~I dont have it~~ ~~m-my pseudo~~ G51652 1983-1992		

WK 8 Ltr #'s part of app

Personal Data ☐

MEDICAL EDUCATION

11. LIST EACH MEDICAL SCHOOL THAT YOU HAVE ATTENDED.

School Name	City, State/Province, Country	Dates of Attendance	L2 Transcript
UNIVERSITY OF VERMONT	BURLINGTON, VT. USA	9/77 - 6/82	☐ ☐
COLLEGE OF MEDICINE			☐ ☐
			☐ ☐

12. School of Graduation	Degree Awarded	Date of Graduation	Diploma
"	M.D.	6/1/82 (5/22)	☐

EXAMINATIONS

13. LIST ALL OF THE FOLLOWING EXAMINATIONS YOU HAVE TAKEN: USMLE, FLEX, NBME, ECFMG, SPEX, STATE BOARDS and/or QME in Canada

Examination	Date	Result (Pass/Fail)	Exams
NBME PARTS 1, 2, 3	1982	[redacted]	☐
			☐
			☐

005678 Cashiering Use Only 4/2/07 505 School Code

L1A

07A-100 (Rev. 12/05)

A "yes" response to Questions 14 through 38 requires a written explanation on a separate sheet of paper along with any supporting materials.

ACGME/RCPSC ACCREDITED POSTGRADUATE TRAINING

MBC Use Only

14. Please list each ACGME/RCPSC accredited postgraduate training program in which you have participated. You must include each internship, residency and fellowship, whether or not the program was completed or credit granted.

Postgraduate Training

Facility Name	Address	Specialty Area	Dates of Attendance
UCLA CENTRE FOR	10833 LE CONTE AVE	OB/GYN	7/82 - 7/86
HEALTH SCIENCES	LOS ANGELES CA		

POSTGRADUATE TRAINING: (These questions are to be answered by ALL applicants)

Did you ever take a leave of absence or break from your training?	YES	NO
Have you ever been terminated, dismissed or expelled from a program?	YES	NO
Have you ever resigned from a training program?	YES	NO
Were you ever placed on probation?	YES	NO
Were you ever disciplined or placed under investigation?	YES	NO
Were any incident reports ever filed by instructors?	YES	NO
Were any limitations or special requirements placed upon you for clinical performance, discipline, or for any other reason?	YES	NO
Have you ever had a postgraduate training program contract not be renewed or offered for a following year?	YES	NO

MEDICAL LICENSURE

15. Please list all medical licenses (other than training licenses) that have ever been issued by any state or territory in the United States or Canadian province.

License Date

Jurisdiction	License Number	Date of Issuance	Dates of Practice in that Jurisdiction
CALIFORNIA	55165 ~~I don't have record~~	1982-3	1982-1987
MASSACHUSETTS	58266	1987	to present
NEW HAMPSHIRE	7744	1988 ~~1989~~	1988-94

APPLICANT: CHRISTINE M. BOULANGER

DATE OF BIRTH:

L1B

07A-100 (Rev. 12/05)

ABMS CERTIFICATIONS

MBC Use Only

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Member Board	Expiration Date	Certificate Number
AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY	VOLUNTARY ANNUAL	
	RECERTIFICATION	

ABMS ☐

MALPRACTICE HISTORY

Malpractice

17. Has a claim or an action ever been filed against you for the practice of medicine which resulted in a malpractice settlement, judgment, or arbitration award of $30,000 or more? YES [redacted] NO [redacted]

PRACTICE IMPAIRMENT OR LIMITATIONS

Limitations

18. Have you been enrolled in, required to enter into, or participated in any drug or alcohol recovery program or impaired practitioner program? YES [redacted] NO [redacted]
19. Have you been treated for or had a recurrence of a diagnosed addictive disorder? YES [redacted] NO [redacted]
20. Have you been diagnosed with an emotional, a mental, or behavioral disorder which impairs your ability to practice medicine safely? YES [redacted] NO [redacted]
21. Have you ever been diagnosed with a neurological or other physical condition that would impair your ability to practice medicine safely? YES [redacted] NO [redacted]
22. Do you have any other condition which in any way impairs or limits your ability to practice medicine safely? YES [redacted] NO [redacted]

If you do receive ongoing treatment or participate in a monitoring program, the Board will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.

CRIMINAL RECORD HISTORY

Criminal Record

23. Have you ever been convicted of, or pled guilty or nolo contendere to ANY offense in any state in the United States or foreign country?

This includes a citation, infraction, misdemeanor and/or felony, etc. If "YES" attach a list of each offense by arrest and conviction dates, violation, and court of jurisdiction (name and address). Matters in which you were diverted, deferred, pardoned, pled nolo contendere, or if the conviction was later expunged from the record of the court or set aside under Penal Code Section 1203.4 MUST be disclosed. If you are awaiting judgment and sentencing following entry of a plea or jury verdict, you MUST disclose the conviction; you are entitled to submit evidence that you have been rehabilitated. Serious traffic convictions such as reckless driving, driving under the influence of alcohol and/or drugs, hit and run, evading a peace officer, failure to appear, driving while the license is suspended or revoked MUST be reported. This list is not all-inclusive. If in doubt as to whether a conviction should be disclosed, it is better to disclose the conviction on the application.

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Applicants who answer "NO" to the question but have a previous conviction or plea, may have their application denied or license revoked for knowingly falsifying the application. YES [redacted] NO [redacted]

APPLICANT: CHRISTINE M. BOULANGER MD

DATE OF BIRTH: [redacted]

L1C

CRIMINAL RECORD HISTORY (cont'd)

MBC Use Only

Criminal Record

24. Is any criminal action pending against you? YES NO

25. Are you required to register as a Sex Offender? YES NO

DISCIPLINARY HISTORY

Discipline

These questions refer to discipline by any U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or country.

26. Have you ever been denied a license to practice medicine? YES NO

27. Is any denial pending against you? YES NO

28. Have you ever been charged with, or been found to have committed, unprofessional conduct, professional incompetence, gross negligence, or repeated negligent acts or malpractice by any medical licensing board, other agency, or hospital? YES NO

29. Have you ever had any license to practice medicine revoked, suspended, or placed on probation? YES NO

30. Have you ever had any license to practice medicine subjected to any action including but not limited to informal or confidential discipline, consent orders, letters of warning, letters of reprimand, or citation? YES NO

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32. Is any disciplinary action pending against any of your licenses to practice medicine? YES NO

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34. Have you ever resigned from a medical staff in lieu of disciplinary or administrative action? YES NO

35. Is any disciplinary action pending against your hospital staff privileges? YES NO

36. Have you ever surrendered a license to practice medicine? YES NO

37. Have your DEA privileges ever been denied, suspended, restricted, or terminated? YES NO

38. Have you ever entered into any arrangement or plea or agreement in lieu of a federal prosecution for a drug violation regulated by the DEA? YES NO

APPLICANT: CHRISTINE M. GOULANGER MD

DATE OF BIRTH:

L1D

[redacted]

Notice: All items in this application, except #8 and #9, are mandatory. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Section 2080 of the California Business and Professions Code, which authorizes the collection of this information. The information on your application may be transferred to other medical licensing authorities, the Federation of State Medical Boards, or other governmental law enforcement agencies. You have the right to review your application subject to the provisions of the Information Practices Act. The Chief of the Licensing Program is the custodian of records.

The applicant, CHRISTINE MARIE BOULANGER MD, [redacted] being first duly sworn upon his/her
(PLEASE PRINT FULL NAME) (DATE OF BIRTH)
oath deposes and says: that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct; that I am the lawful holder of the degree of Doctor of Medicine as prescribed by this application, that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted, were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof. Further, I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past, present and future), business and professional associates (past, present, and future), and all government agencies (local, state, federal, or foreign) to release to the Medical Board of California or its successors any information, files or records, including medical records, educational records, and records of psychiatric treatment and treatment for drug and/or alcohol abuse or dependency, requested by that Board in connection with this application; or any further or future investigation by that Board necessary to determine any medical competence, professional conduct, or physical or mental ability to safely engage in the practice of medicine. I further authorize the Medical Board of California or its successors to release to the organizations, individuals or groups listed above any information which is material to this application or any subsequent licensure.

I UNDERSTAND THAT FALSIFICATION OR MISREPRESENTATION OF ANY ITEM OR RESPONSE ON THIS APPLICATION OR ANY ATTACHMENT HERETO IS A SUFFICIENT BASIS FOR DENYING OR REVOKING A LICENSE. CB **(PLEASE INITIAL BOX)**

SIGNATURE OF APPLICANT: Christine M. Boulanger MD.
(Please sign full name)

State of Massachusetts

County of Middlesex

Subscribed and sworn to (or affirmed) before me on

this 23rd day of March, 20 07,

by Christine M Boulanger MD

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL
KIMBERLY A. MELLO
Notary Public
Commonwealth of Massachusetts
My Commission Expires Nov 6, 2013

Kimberly A. Mello
SIGNATURE OF NOTARY PUBLIC

L1E

07A-100 (Rev. 12/05)

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF MEDICAL EDUCATION

MEDICAL SCHOOL: PLEASE COMPLETE THIS FORM IN THE ENGLISH LANGUAGE

This certifies that CHRISTINE MARIE BOULANGER ; [redacted]
Full Name of Applicant — U.S. Social Security Number

[redacted] enrolled in UNIVERSITY OF VERMONT COLLEGE OF MEDICINE.
Date of Birth — Name of Medical School

located in BURLINGTON, VERMONT USA on 09/01/1977.
State/Province Country — Enrollment Date

The undersigned further certifies that the records of this institution show that the applicant attended in this institution 4 years of resident instruction, completing at least 4,000 hours, of which at least 80 percent actual attendance is required in the subjects set forth hereunder (Business and Professions Code Sections 2089,2089.5, 2089.7,2090, 2091.1,2091.2) and that the applicant

Anatomy	Embryology	Physical Medicine
Otolaryngology	Histology	Therapeutics
Obstetrics and Gynecology	Human Sexuality	Neuroanatomy
Radiology, including Radiation Safety	Medicine	Child Abuse Detection and Treatment
Tropical Medicine	Surgery, including Orthopedic Surgery	Geriatric Medicine
Physiology	Urology	Pediatrics
Biochemistry	Psychiatry	Pharmacology
Pathology, Bacteriology, and Immunology	Neurology	Anesthesia
Ophthalmology	Alcoholism and Chemical Dependency	Spousal Partner Abuse Detection & Treatment*
Dermatology	Preventative Medicine, including Nutrition	Family Medicine**
		Pain Management and End-of-Life-Care***

* ONLY applicable to medical students who enrolled in medical school on or after September 1, 1994.
** ONLY applicable to medical students who graduate from medical school on or after May 1, 1998.
*** ONLY applicable to medical students who enrolled in medical school on or after June 1, 2000.

☑ was granted the degree of Bachelor/Doctor of Medicine on the 22 day of MAY, 1982.

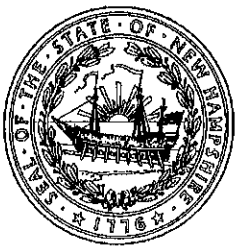
☐ withdrew from medical school on ____ day of _____, _____.

Unusual Circumstances	Responses	
Did this individual ever take a leave of absence from their medical education?	Yes [redacted]	No [redacted]
Was this individual ever placed on probation?	Yes [redacted]	No [redacted]
Was this individual ever disciplined or under investigation?	Yes [redacted]	No [redacted]
Were any incident reports regarding this individual ever filed by instructors?	Yes [redacted]	No [redacted]
Were any limitations or special requirements imposed on this individual because of questions of academic or disciplinary problems, or for any other reason?	Yes [redacted]	No [redacted]

A "Yes" response to ANY of the above questions requires the medical school to provide a written explanation on a separate attachment. [redacted]

Medical School Seal Must Be Imprinted Below	Attention Medical School: Only the President, Dean, or Registrar may sign this form. If the signature is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.
	Signed and the school seal affixed this 8th day of March, 2007.
	By: Jim Leahy, Administrative Assistant (Printed Name and Title of School Official)
	Signature: [signature]

L2



New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.state.nh.us/medicine

This is to certify that the records of the New Hampshire Board indicate the following information:

LICENSEE: Christine M Boulanger

LICENSE NUMBER: 7744

ISSUE DATE: 12-2-87

EXPIRATION DATE: 6-30-94

DISCIPLINARY ACTION: NONE

DATE: 3-14-08

To expedite the certification of licensure process, the above is the standard format for all professionals regulated by the Board.

Nichole Taylor
License Clerk

(SEAL)

Massachusetts Board of Registration in Medicine Physician Profile

Christine Marie Boulanger, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status:	**Active**
License Issue Date:	8/1/1987
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Hospital
Business Address:	22 Mill Street #102 Arlington, MA 02476
Phone:	[redacted]
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	Martha's Vineyard Hospital (Associate) Mount Auburn Hospital (Active)

II. Education & Training

Medical School:	University of Vermont College of Medicine
Graduation Date:	1982
Post Graduate Training:	None Reported

III. Specialty

Area of Specialty:	Obstetrics and Gynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Obstetrics & Gynecology	Obstetrics and Gynecology	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

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

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Boulanger has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Boulanger has had no criminal convictions in the past ten years.

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

Dr. Boulanger has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Boulanger has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 617-654-9830
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

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Rec'd 3/21/08

UNIVERSITY OF CALIFORNIA, LOS ANGELES

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SANTA BARBARA • SANTA CRUZ

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
UCLA SCHOOL OF MEDICINE
CENTER FOR THE HEALTH SCIENCES
10833 LE CONTE AVENUE
LOS ANGELES, CALIFORNIA 90095-1740
FAX: (310) 206-3670

March 17, 2008

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95828-3236

RE: Christine M. Boulanger, M.D.

To Whom It May Concern:

This letter is to confirm that Christine Boulanger, M.D. was a resident in good standing in the Department of Obstetrics and Gynecology at UCLA. Dr. Boulanger started the program on June 24, 1982 and successfully completed her training on June 23, 1986.

If you have any further questions, please call me at [redacted]

Sincerely,

Gautam Chaudhuri

Gautam Chaudhuri, M.D., Ph.D.
Professor
Department of Molecular and Medical Pharmacology
Professor and Executive Chair
Department of Obstetrics and Gynecology

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2487
www.caldocinfo.ca.gov

CERTIFICATE OF COMPLETION OF ACGME/RCPSC POSTGRADUATE TRAINING

To be completed by the facility for every medical school graduate completing postgraduate training in the United States or Canada.

PART 1: TO BE COMPLETED BY THE APPLICANT

NAME: Last BOULANGER First CHRISTINE Middle MARIE

U.S. Social Security Number [redacted] Date of Birth [redacted] Telephone Number Home [redacted] Work [redacted]

Public/Mailing Address ~~49 MYRTLE ST. #4~~ 432 CLAY STREET

City ~~BOSTON~~ MONTEREY State/Province ~~MA~~ CA. Zip/Postal Code ~~02114~~ 93940.

Medical School of Graduation: UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

PART 2: TO BE COMPLETED BY THE PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: Do not sign and date this form before the last day of any postgraduate training year which will be used by the applicant to qualify for licensure. Completion of this form will certify that the individual named in PART 1 above satisfactorily completed a period of accredited postgraduate training at this facility and that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

Name of Facility: UCLA CENTRE FOR HEALTH SCIENCES DEPT. OF OBGYN RM. 27-117 ACGME 10 digit Program number: (www.acgme.org) 2200531038

Address of Facility: 10833 LECONTE AVENUE LOS ANGELES CA 90095-1740 Telephone #: [redacted]

Categorical Specialty Area of Training: OB/GYN Start Date of Training: 06, 24, 1982 End Date (or anticipated completion date) of Training: 06, 23, 1986

UNUSUAL CIRCUMSTANCES:

Did the trainee ever take a leave of absence or break from their training?	YES [redacted]	NO [redacted]
Was the trainee ever terminated, dismissed or expelled?	YES [redacted]	NO [redacted]
Did the trainee ever resign?	YES [redacted]	NO [redacted]
Was the trainee ever placed on probation?	YES [redacted]	NO [redacted]
Was the trainee ever disciplined or placed under investigation?	YES [redacted]	NO [redacted]
Were any incident reports regarding this trainee ever filed by instructors?	YES [redacted]	NO [redacted]
Were any limitations or special requirements placed upon the trainee for clinical incompetence, disciplinary problems or for any other reason?	YES [redacted]	NO [redacted]
Did the program decline to renew or offer the trainee a postgraduate training program contract for a following year?	YES [redacted]	NO [redacted]

A "Yes" response to ANY of the above questions requires the program director to provide a written explanation on a separate attachment.

L3A

DEFINITION OF "SATISFACTORY" COMPLETION OF TRAINING

The program director signing this form is formally certifying and documenting under penalty of perjury that the trainee received instruction appropriate for the particular postgraduate level and that he/she satisfactorily completed periods of training in accordance with the accepted standards and the criteria defined as equating to "satisfactory" performance as described below. The program director will personally be attesting to the fact that the trainee has acquired the skill and qualifications necessary to safely assume the unrestricted practice of medicine in this state.

"SATISFACTORY" IS DEFINED AS: THE TRAINEE PERFORMED AT AN ADEQUATE LEVEL BASED ON EVIDENCE OF SATISFACTORY PROGRESSIVE GROWTH INCLUDING DEMONSTRATED ABILITY TO ASSUME GRADED AND INCREASING RESPONSIBILTY FOR PATIENT CARE.

GENERAL MEDICINE TRAINING REQUIREMENT

To qualify for licensure in California, applicants who are graduates of an international medical school must complete **at least four months** of postgraduate training in GENERAL MEDICINE as part of the requirement. Applicants who are graduates of a U.S. or Canadian medical school, who have not completed postgraduate training required for licensure by July 1, 1990, must also complete four months of training in GENERAL MEDICINE prior to licensure. The GENERAL MEDICINE requirement may be satisfied by actual clinical practice where the applicant has direct patient care responsibilities in any particular specialty or sub-specialty area for at least four months.

I hereby certify as the program director, that the individual named in Part 1

☒ **has completed** ☐ **has not completed**

a minimum of four months of general medicine as part of this postgraduate training program accredited by the ACGME or the RCPSC.

SIGNATURE OF PROGRAM DIRECTOR

ATTENTION PROGRAM DIRECTOR: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Each delegation must be on official letterhead and must be dated within the last 12 months.

HOSPITAL SEAL

OFFICIAL HOSPITAL SEAL MUST BE AFFIXED IN THE BOX TO THE LEFT TO CERTIFY TRAINING

The training program is accredited by the ACGME or the RCPSC to offer the type and level of training completed by the applicant, and the applicant was trained in an accredited ACGME or RCPSC program position. I hereby declare under penalty of perjury under the laws of the State of California that the statements are true and correct.

Gautam Chaudhuri, M.D., Ph.D.

PRINT NAME OF PROGRAM DIRECTOR

03/12/08

SIGNATURE OF PROGRAM DIRECTOR **DATE SIGNED**

Signature Stamp Is Not Acceptable

If a hospital seal is not available, the program director shall sign this form in the presence of a notary public.

State of _____

County of _____

Subscribed and sworn to (or affirmed) before me on

this _____ day of _____, 20_____,

by _____

personally known to me or proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

NOTARY SEAL

SIGNATURE OF NOTARY PUBLIC

L3B

Medical Board of California – Physician's and Surgeon's Renewal

LICENSEE NAME	LICENSE NO.	EXPIRATION DATE	AMOUNT DUE NOW	AMOUNT DUE IF POSTMARKED AFTER APRIL 30, 2018
BOULANGER, CHRISTINE M	**G51652**	**03/31/18**	**$820.00**	**$898.00**

LICENSEE MUST CHECK CORRECT BOXES

"H" [redacted] Completed Continuing Education (See Question 1)

"E" Change of Address (fill in reverse side)

"I" Conviction [redacted]

"J" Conviction [redacted]

"F" Family Physician Training Program ($25 See Question 4)

"G" [redacted] Financial Interest Statement [redacted]

"D" **SIGNATURE REQUIRED**

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations on this form, including supplementary attached hereto, are true, complete and accurate.

Signature Christine M. Boulanger MD Date 12/29/2017

ENTER YOUR PHONE NUMBER FOR REFERENCE: [redacted]

630107000007000060005165260103311800082000000089800

CHANGE OF ADDRESS (Only if different from address above) **BOULANGER, CHRISTINE M** **G51652**

ADDRESS OF RECORD (Required)

Address Line 1

Address Line 2

Address Line 3

City State Zip

CONFIDENTIAL STREET ADDRESS (Required if PO Box used above for Address of Record)

Address Line 1

Address Line 2

Address Line 3

City State Zip

Application Summary

License Type:	**Physician and Surgeon G**
License Number:	**51652**
File Number:	**201925**
Application:	**Physician's and Surgeon's Renewal**
Application Number:	**14254954**
Application Date:	**02/16/2016 (mm/dd/yyyy)**

Application Questions

Have you served or are you currently serving in the military? [redacted]

Personal Detail

First Name:	**CHRISTINE**
Middle Name:	**MARIE**
Last Name:	**BOULANGER**
Birthdate:	****/**/******
Gender:	**Female**

Addresses

License Related Addresses

Address of Record (Required)

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Confidential Address

Warning: **In order to protect your privacy and identity, address will not be displayed.**

Questions

Since you last renewed your license, have you had any license disciplined by a government agency or other disciplinary body, or, have you been convicted of any crime in any state, the U.S.A. and its territories, military court or a foreign country? [redacted]

Have you successfully completed, and can document, the mandatory courses and hours of CME within the last two years, or you meet the conditions which would exempt you from all or part of the CME requirements, or you hold a permanent CME waiver? [redacted]

I certify under penalty of perjury, under the laws of California, that I have disclosed the names of those health-related facilities in which I or my family have a financial interest OR I declare under penalty of perjury I have no financial interests to disclose. [redacted]

Family Physician Training Program Voluntary Fee

Voluntary Fee:	**No**

Attachments

Physician Survey

Are you retired?	**No**
Activities in Medicine	**Administration - 1-9 Hours**
	Other - None
	Patient Care - 20-29 Hours
	Research - None
	Teaching - 1-9 Hours
	Telemedicine - None
Patient Care Practice Location	**Zip: 93940 County: MONTEREY**
Telemedicine Practice Location	**Zip: County:**
Patient Care Secondary Practice Location	**Zip: County:**
Telemedicine Secondary Practice Location	**Zip: County:**
Current Training Status	**Not in Training**
Areas of Practice	**Obstetrics and Gynecology - Primary**
Board Certifications	**American Board of Obstetrics and Gynecology - Obstetrics and Gynecology**
Cultural Background	[redacted]
Web Site Profile	**Cultural Background - No**
	Foreign Language Proficiency - No
	Gender - Yes
E-mail:	[redacted]

Fees

Biennial Renewal Fee	**$783.00**
DUE TO CURES FUND	**$12.00**
Steven M. Thompson Physician Corps Loan Repayment Program	**$25.00**

Total Amount Due: **$820.00**

Applications are not considered submitted for processing until payment is received.

Attestation

I declare under penalty of perjury under the laws of the State of California that all statements, answers, and representations provided, including supplementary attached hereto, are true, complete and accurate.

Signature: Date: