# COMMONWEALTH OF MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES Department of Public Health Bureau of Health Care Safety and Quality 99 Chauncy Street, 11th Floor, Boston, MA 02111-1212 (617) 753-8000

		I	Date:	120/19	_
арр	accordance with the "Regi lies for a license to establ he General Laws, Chapter	ish and/or maintain a ci	linic at the pre	05 CMR 140", the und emises set forth below	dersigned hereby under provisions
1.	NAME OF LICENSEE:	Four Wor	nen Hec	alth Service	2
2.	NAME OF CLINIC: -	Same		<u> </u>	<del></del>
3.	ADDRESS: 150 Street	Emory St St	rite same) AHlek City or Town	OO CO Zip	7703 Code
4.	TELEPHONE: 508.	222.7555	EMAIL:	FWHS 7555	2, gmail.com
5.	LICENSE NUMBER:	4441	Date current li	cense expires: 6/1	4/19
6.	SERVICES (check all the	nat apply)			
	Medical	Substance Abuse		Dental	
	Surgical	Physical Rehabilitation	1 ———	Mental Health ——	
	Birth Center———	Mobile Medical		Transfusion	
	Pharmacy	Limited Services —			
7.	NAME OF CLINIC	ADMINISTRATOR: _			i W

N/N

Clinic Name	 
Application Date	

Name of Clinic:				
Street:	Suite #/Floor	City/Zip Code		
Telephone Number:	Days and Hours of Ope	eration:		
Services offered:		<u> </u>		
Department of Public Safety	Certificate Issued: Fire	Certificate Issued:		
Substance Abuse Certificate	Issued:			
Name of Clinic:				
Street:	Suite #/Floor	City/Zip Code		
Telephone Number:	Days and Hours of Ope	eration:		
Services offered:				
Department of Public Safety	Certificate Issued: Fire	Certificate Issued:		
Substance Abuse Certificate	: Issued:			
Name of Clinic:				
Street:	Suite #/Floor	City/Zip Code		
	Days and Hours of Ope	eration:		
Telephone Number:				
_				

(Attach addendum for additional sites, if applicable)

	Application Date 5/29/19
9.	Number of patients per year: Less than 5,000  5,000 - 25,000  25,000 - 100,000  100,000
10.	I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.
•	Federal identification Number
	Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A:
11.	Signature and Seal:
	say that the statements contained in this license applicat my knowledge.*  Signature of Applicant (murviduar of Ferson authorized act in behalf of the Individual Applicant) or Corporate Name
	By:  Corporate Officer (if applicable)
Sub	escribed and sworn to before me on this 23 day of May 20 19
Му	commission expires on $8/13/2021$ 20 $21$
	My Roya (Seal)
42.7	AFIA-BARZAN ROSTAMI Notary Public, Commonwealth of Massachuselts My Commission Expires August 13, 2021

Clinic Name Four Women Health Services

## COMMONWEALTH OF MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES Department of Public Health Bureau of Health Care Safety and Quality

99 Chauncy Street, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

арр	ccordance with the "Regu lies for a license to establi he General Laws, Chapter	ish and/or maintain a cl	linic at the pre	5 CMR 140", th mises set forth b	e undersigned here. elow under provisio	by ons
1.	NAME OF LICENSEE:	Four Women	Health S	bervices		
2.	NAME OF CLINIC: —	Same			* * * * * * * * * * * * * * * * * * * *	
3.	ADDRESS: 150 E Street	mory St. (if same, w	rite same) Attle City or Town	bero	<i>02703</i> Zip Code	
4.	TELEPHONE: 508					com
5.	LICENSE NUMBER:	44HL	Date current li	cense expires: _	06/14/2017	
6.	SERVICES (check all the	nat apply)				
	Medical	Substance Abuse		Dental		
	Surgical	Physical Rehabilitation	n	Mental Health		
	Birth Center ———	Mobile Medical		Transfusion _		
	Pharmacy	Lithotripsy —		Limited Service	es	
7.	NAME OF CLINIC	ADMINISTRATOR:				

Clinic Name <u>Four Women Heat</u>th Sewiss

Application Date <u>04|20|7017</u>

Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of	f Operation:
Services offered:		
Department of Public Safety (	Certificate Issued:	Fire Certificate Issued:
Substance Abuse Certificate I	ssued:	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours o	of Operation:
Services offered:		
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:
Substance Abuse Certificate l	ssued:	-
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of	of Operation:
Services offered:		
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:
Culatara Abras Contificato	Issued:	

Clinic Name Four Women Heatth Services
Application Date 04/20/2017

9.	Number of patients per year: Less than 5,000  5,000 - 25,000  25,000 - 100,000  100,000
10.	I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.
	Federal Identification Number
	Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.
11.	Signature and Seal:
	I,
	By: Corporate Officer (if applicable)
Sub	oscribed and sworn to before me on this ZC day of April 20 17.
Му	oscribed and sworn to before me on this ZC day of April 20 17.  commission expires on April ZC 20 23.
4	Seal)
2No	JACOB B. BOYER
*N	ote: All information contained in this application must be kept current.  Notary Public Massachusetts Commission Expires Apr 20, 2023

Rev. 03/25/13

COMMONWEALTH OF MASSACHUSETTS

RECEIVE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Public Health

Bureau of Health Care Safety and Quality

Bureau of Health Floor, Boston, MA 02111-1212

(617) 753-8000

#### APPLICATION FOR CLINIC LICENSE RENEWAL

	Date: 4/4/13
aρį	accorderce with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby plies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 111, Section 51 and 56.
1.	NAME OF LICENSEE: Four Women Health Services
2.	NAME OF CLINIC: Same Four Women Heath Senices
3.	ADDRESS: 150 Emory Street Atteboro MA 02703 Street City or Town Zip Code
4.	TELEPHONE: 508-222-7555 EMAIL:
5,	LICENSE NUMBER: 4411  Date current license expires: 41113
6.	SERVICES (check all that apply)
	Medical Substance Abuse Dontal
	Surgical — Physical Rehabilitation — Mental Health —
	Birth Center Mobile Medical Transfusion
	Pharmacy Radiology (MRI) Limited Services
7.	NAME OF CLINIC ADMINISTRATOR:

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MA Dept of Public Health 99 Chauncy Street Boston, MA. 02111

# COMMONWEALTH OF MASSACHUSETTS RECEIVE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES Department of Public Health Bureau of Health Care Safety and Quality Market Street, 11th Floor, Boston, MA 02111-1212 (617) 753-8000

#### APPLICATION FOR CLINIC LICENSE RENEWAL

11.11.

	Date: 4/4/13
apj	accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby plies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 111, Section 51 and 56.
1.	NAME OF LICENSEE: Four Women Health Services 200
2.	NAME OF CLINIC: Same
3.	ADDRESS: 150 Emory Street Atteboro MA 02703  Street City or Town Zip Code
4.	TELEPHONE: 508. 222. 7555 EMAIL:
5.	LICENSE NUMBER: 4441  Date current license expires: 61413
6.	SERVICES (check all that apply)
	Medical Substance Abuse Dental
	Surgical — Physical Rehabilitation — Mental Health —
	Birth Center — Mobile Medical Transfusion
	Pharmacy Radiology (MRI) Limited Services
7.	NAME OF CLINIC ADMINISTRATOR:

•		Clinic 1	Name	<del></del>
	•	Applica	ation Date	
8.	NAME AND ADDRESS OF ALL SATE	LLITE LOCATION	IS MAINTAINED UNDER LIC	CENSEE
1.	Name of Clinic:			<del></del>
		G '- 1/101		<del></del>
	Street:	Suite #/Floor	City/Zip Coo	
	Telephone Number:	-	-	
	Services offered:			_
	Department of Public Safety Certificate	Issued:	Fire Certificate Issued:	<del></del>
	Substance Abuse Certificate Issued:		_	
2.	Name of Clinic:			
	Street:	Suite #/Floor	City/Zip (	Code
	Telephone Number:	Days and Hour	s of Operation:	<del></del>
	Services offered:			_
	Department of Public Safety Certificate	Issued:	_ Fire Certificate Issued:	<del></del> -
	Substance Abuse Certificate Issued:		·	
3.	Name of Clinic:			
	Street:	Suite #/Floor	City/Zip (	Code
	Telephone Number:	Days and Hour	s of Operation:	
	Services offered:			——
	Department of Public Safety Certificate	Issued:	_ Fire Certificate Issued:	
	Substance Abuse Certificate Issued:		_	
(Atta	ch addendum for additional sites, if applicable)			

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Clinic Name Foo	ur Wome	n Heath
Application Date	4/4/13	Services
. ippiivaiion Dato	', , -	

9.	Number of Outpatients per year Less than 5,000
	5,000 – 25,000 ———
	25,000 – 100,000
	100 000 -

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

Federal Identification Number

Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.

11. Signature and Seal:

say that the statements contained in this needse app	, being first duly sworn on oath depose and plication are true, complete and correct to the best of	
my knowledge.*	Signature of Applicant (Individual or Person authorized	a
	in behalf of the Individual Applicant) or Corporate Nam	
	By:	_
	Corporate Officer (if applicable)	
Subscribed and sworn to before me on this	_day of <u>April</u> 20 <u>13</u>	
My commission expires on	20 1 .	
YMOTA I. Rivet	(Seal)	
Notary Public	KRISTA LYN RIVET	
Notary My	ry Public, Commonwealth of Massachusetts y Commission Expires &ovember 10, 2017	
*Note: All information contained in this application mu	ust be kept current.	
· · · · · · · · · · · · · · · · · · ·		

Rev. 03/25/13

(E)

#### COMMONWEALTH OF MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Public Health
Bureau of Health Care Safety and Quality
99 Chauncy Street, 2<sup>nd</sup> Floor, Boston, MA 02111-1212
(617) 753-8000

#### APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4.15.09

ар	accordance with the "Reg plies for a license to estab the General Laws, Chapte	lish and/or maintain a	clinic at the pr		
1.	NAME OF LICENSEE	:-			
2.	NAME OF CLINIC:	FOUR WOMEN	U HEALT	H SERVI	CES
3.·	ADDRESS: 150 Street	EMORY ST.	write same) ATTLEE City or Town	BORO, MA	O2703 Zip Code
4.	TELEPHONE: (508)	)222-7555	. FAX:	(508) 226	-2218
5.	LICENSE TYPE: RENEWAL LICENS	SE: X	Date current li	icense expires $\omega$	114109
6.	SERVICES (check all t	hat apply)			() ()
	Medical	Substance Abuse		Dental 🗓	AT LH
	Surgical	Physical Rehabilitation	on	Mental Health _	CA ·
	Birth Center —	Mobile Medical		Transfusion	9: CU
	Pharmacy	Radiology (MRI) —	· .	j	19: 39
7.	NAME OF CLINIC	ADMINISTRATOR:			

### Clinic Name TOUR WOHEN HEALTH SERVICES Application Date 4.15.09

Name of Clinic:	~ NONE ~		
Street:	Suite #/Floor	City/Zip C	ode
Telephone Number:	Days and Hours	s of Operation:	
Services offered:		<u> </u>	
Department of Public Safety	Certificate Issued:	_ Fire Certificate Issued:	
Substance Abuse Certificate	Issued:		
Name of Clinic:		<u> </u>	
Street:	Suite #/Floor	City/Zi	p Cod
Telephone Number:	Days and Hours	s of Operation:	
Services offered:			
Department of Public Safety	Certificate Issued:	_ Fire Certificate Issued:	
Substance Abuse Certificate 1	Issued:	<u> </u>	
Name of Clinic:			
Street:	Suite #/Floor	City/Zij	o Code
Telephone Number:	Days and Hours	of Operation:	
Services offered:			
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:	<u></u>
	Issued:		

Clinic Name Tour	WOMEN HEALTH SERVICES
Application Date	4.15.09

•	Application Date
9. Number of patients per year:	
Less than 5,000	·
5,000 – 25,000	•
25,000 – 100,000	
100,000 -	
10. I certify under the penalties of perjury that I, to returns and paid all state taxes required under law	· ·
Social Security Number (Voluntary)	•
or Federal Identification Number	
whether you have met tax filing or tax payment of	shed to the Massachusetts Department or Revenue to determine obligations. Licensee who fail to correct their non-filing or tax ext their non-filing or delinquency will be subject to license under the authority of Mass. G. L. c.62C s.49A.
11. Signature and Seal:	•
	•
	, being first duly sworn on oath depose and
say that the statements contained in this license ap	
my knowledge.*	
, ,	
	Digitalitate of Tippineans (Individual of Teleofi wanterines ass
• .	in behalf of the Individual Applicant) or Corporate Name
•	Ву
	Corporate Officer (if applicable)
Subscribed and sworn to before me on this 30h	w day of April 2009.
My commission expires on Aug - 3.	2012.
Kjindal	(Seal)
Notary Public 4-30-09	AND
<b>,</b>	

\*Note: All information contained in this application must be kept current.

		Clinic Name 00	4 WOINA
		Application Date	2.23.07
8. N	JAME AND ADDRESS OF ALL S	ATELLITE LOCATIONS MAINTAINED U	NDER LICENSEĖ
SAT	ELLITES:		
1.	Name of Clinic:	None	
		•	
	Street:	Suite #/Floor	City/Zip Code
	Telephone Number:	Days and Hours of Operation:	
	Services offered:		<del></del>
	DPS Issued	Fire Issued	
2.	Name of Clinic:	None	
	•		
	Street:	Suite #/Floor	City/Zip Code
	Telephone Number:	Days and Hours of Operation:	
	Services offered:		
	DPS Issued	Fire Issued	
3.	Name of Clinic:	None	
	Street:	Suite #/Floor	City/Zip Code
·	Telephone Number:	Days and Hours of Operation:	
	Services offered:	· · · · · · · · · · · · · · · · · · ·	
	DPS Issued:	Fire Issued:	
	(Attach addendum for additional	sites, if applicable)	

•	Clinic Name —	Four Women
•		2.23.07
·	Application Date	
9. Number of patients per year:		
Less than 5,000		•
5,000 – 25,000 ————		•
25,000 – 100,000 <u> </u>		
' 10. I certify under the penalties of perjury that I; to me returns and paid all state taxes required under law		have filed all state tax
	•	• .
Social Security Number (Voluntary) or Federal Identification Number		:
or rederal identification Number		
Note: Your social security number will be furnish determine whether you have met tax filing or tax p filing or tax payment obligations. Licensees who to license suspension or revocation. This request it	payment obligations. License fail to correct their non-filing	e who fail to correct their non- or delinquency will be subject
•	,	
11. Signature and Seal:		•
	, being first duly swor	on oath depose and
say that the statements contained in this likense app	plication are true, complete an	d correct to the best of
my knowledge.*		
	Signature of Applicant (Inc	dividual on Donner and ariand
	act in behalf of the Individ	lividual or Person authorized ual Applicant) or Corporate
Bristol County Messachusetts Before me the understand public personally appeared porced with a Messachusetts diverse	Name I	
public oursingly appeared	·	
proved with a Massachusetts dinver	Corporate Officer (if a	mlicable)
JEENSC 221	- Conposate Critical (in al	2400
Subscribed and sworn to before me on this	day of February 19	<u> 400 /                                  </u>
My commission expires on	29 to	2011
Deboron Dong (Seal)	) Debarah	1 Denov
Notary Public	Deborah Notary Commonwealth, c	Public
	My Commiss December	ion Expires
*Note: All information contained in this application m		•

DPHCQ 136 Rev. 10/05/05

# COMMONWEALTH OF MASSACHUSETTS CARE QUALITY Department of Public Health DIVISION OF HEALTH CARE QUALITY 99 Chauncy Street BOSTON, MA 02111-1212 (617) 753-8000 PECFIVED

	Date: 2.23.07
арр	accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby blies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 111, Section 51 and 56.
1.	NAME OF LICENSEE FOUR Women, Inc
2.	NAME OF CLINIC Four Women
3.	ADDRESS 150 Emony Street, attleboro, WA 02703  Street City or Town Zip Code
4.	TELEPHONE 508.222.1555
5.	LICENSE TYPE:
	(A) RENEWAL LICENSE Date current license expires 12/11/06
6.	SERVICES (check all that apply)
	Medical — Alcoholism — Dental — —
	Surgical — Physical Rehabilitation — Mental Health — —
	Birth Center — Mobile Medical — Transfusion
	Pharmacy MRI Radiology
7.	NAME OF CLINIC ADMINISTRATOR

ASC - A052

## COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH CARE QUALITY 99 CHAUNCY STREET BOSTON, MA 02111 TELEPHONE (617) 753-8000

USTALTH CARE QUALITY

#### APPLICATION FOR CLINIC LICENSE

	DATE:6 107	RECEIVED
a lice	accordance with the "Regulations for the Licensure of Clinics, 105 CMR 140", the icense to establish and/or maintain a clinic at the premises set forth below under papter 111, Sections 51 and 56.	te undersigned hereby applies for provisions of the General Laws,
1.	NAME OF APPLICANT	
2.	NAME OF CLINIC FOUR WOMEN HEATH	Services, LLC
3.	ADDRESS 150 EMOTY St, Att 1ek (Street) (City/Town)	poro, NA 02703 (Zip Code)
4.	TELEPHONE 508 222 7555	
5.	LICENSE TYPE:	. •
	(A) RENEWAL LICENSE: Date current License	e expires
	(B) ORIGINAL LICENSE:	
	(a) Initial Establishment: Projected opening	g date:
	(b) Change of Location: Projected openin	
	(c) Transfer of Ownership: Date:6	15/07
	(d) Determination of Need Project Number:	· · · · · · · · · · · · · · · · · · ·
	Date Approved:	-
6.	SERVICES (check all that apply)	• • •
	Medical Mental Health	Dental
	Surgical Physical Rehabilitation	Alcoholism
	Birth Center	
7.	NAME AND ADDRESS OF SATELLITE LOCATIONS MAINTAINEI (use separate sheet if necessary)	UNDER LICENSE:

8. NAME OF CLINIC ADMINIST

Clinic Name	Four	M	∂Me	4	Health	Service	ces, LLC
Application Date		6.	1	0	7		

9.	PLEASE CHECK	<b>CATEGORY</b>	WHICH BEST	DESCRIBES	APPLICANT
----	--------------	-----------------	------------	-----------	-----------

a)	Governmental Ownership			
b)	Sole Proprietorship (Individual)	•		
c)	Partnership (if limited, please check)			
d)	charitable (G.L.C. 180) Corporation			
e)	Proprietary (G.L.C. 156A or 156B)			
n.	Other (specify exact nature)			

#### 10. IDENTITY OF APPLICANT - Specify below:

- If the applicant is an individual, partnership or trust, the names and ownership percentages of such individual, partners or trustees, except that, in the case of a limited partnership, such information shall be provided only for each general partner and those limited partners owning five per cent or more of the partnership interest.
- If the applicant is a for profit corporation, the names of all stockholders who hold five percent or more of any class of the outstanding stock, specifying the percentage owned.
- c) If the applicant is a not-for-profit corporation, the names of the members of the corporation.
- d) The name and ownership percentage of each person who directly, or indirectly has any ownership interest of five percent or more, unless otherwise provided pursuant to a), b), or c) above.
- e) The names of the directors, if corporation.



			Application	Date	Women 6/1/	01		٠.
RESP	ONSIBILITY AN	D SUITABILI	ŗ <b>y</b>				,	
Has th		f; acted as a guara	antor or co-signe	ed for the de				
	mat has been the	e subject of a bar Yes	No					
•	If yes, describe:	•					,	
	. •						•	•
		. •		•				
b) ·	Has applicant*,	or any of its offi		or its clinic a	dministrator	ever been indi	icted or form	ally
		y criminal offens	se?					
		-	se? No	_		-		•
	charged with an	-	No	convicted, o				tendere
	charged with an  If yes, was the a	Yesapplicant or clinion a judicial proce	No	convicted, o				tendere
	If yes, was the a or admit facts in	Yesapplicant or clinion a judicial proce	No N	convicted, or a finding	g of guilt, in r	esponse to the	ose charges?	. :
	If yes, was the a or admit facts in	Yes applicant or clinic n a judicial proce Yes the second ques	No N	convicted, or a finding	g of guilt, in r	esponse to the	ose charges?	. :
	If yes, was the a or admit facts in	Yes applicant or clinic n a judicial proce Yes the second ques	No N	convicted, or a finding	g of guilt, in r	esponse to the	ose charges?	. :
	If yes, was the a or admit facts in	Yes applicant or clinic n a judicial proce Yes the second ques	No N	convicted, or a finding	g of guilt, in r	esponse to the	ose charges?	. :
	If yes, was the a or admit facts in	Yes applicant or clinic n a judicial proce Yes the second ques	No N	convicted, or a finding	g of guilt, in r	esponse to the	ose charges?	. :
c)	If yes, was the a or admit facts in If the answer to which they were officer or admir or any other juri	Yes applicant or clinic n a judicial proce Yes the second ques	No c administrator of eding sufficient No tion is yes, exploit number(s), and or a partnership ealth care facilit, suspend, revok	convicted, or for a finding ain, including the outcome of the interest of fix which has see, refuse or	g of guilt, in regions of the nature of the proces	of the charges, sedings:	member, dire	ctor,

<sup>\*</sup> For the purposes of this question, applicant means the proposed holder of the license identified in item 1 of this application and any person identified in items 10 a) through d) of this application.

Four Women Health Services, LLC

	Application Date 6107
12.	IF THE PREMISES ARE LEASED, GIVE NAME AND ADDRESS OF OWNER AND THE TERM OF THE LEASE: (Specify by site if satellites are involved
	Landlord: Dr. Mark Robbin at RJ Realty, LLC 150 Emory St Attleboro, MA OJ lease extends to 2011
13.	NUMBER OF VISITS PER YEAR:
	Less than 5,000
	5,000 - 25,000
	25,000 - 100,000
	100,000 +
14.	I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns aw. ID Four women Health Services
	or Federal Identification Number
	Note: Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c.62C s.49A.

SIG	NATURE and SEAL		
a) .		, being first duly sworn on oath depose and say that the	
	statements contained in this license application are	transfer to the board of the bo	
·			
,		Signature of Applicant (Individual or Person authorized	
		to act in behalf of the Individual Applicant) or Corporate  Name	Seaviles, LLC
		Ву:	<u> </u>
Subs	scribed and sworn to before me on this	_day of <u>Juno</u> , 2007.	·
Му	commission expires on Sept. 27	, 2013	
Nota	Ingling Contabo	(Seal)	
	V	· · · · · · · · · · · · · · · · · · ·	



15.

(C)

## COMMONWEALTH OF MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES Department of Public Health Bureau of Health Care Safety and Quality 99 Chauncy Street, 2<sup>nd</sup> Floor, Boston, MA 02111-1212 (617) 753-8000

	Date: 4/7/11
арр	ccordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby lies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 111, Section 51 and 56.
1.	NAME OF LICENSEE: Four Women Health Services
2.	NAME OF CLINIC:
3.	ADDRESS: 150 Emory St Attleboro MA 02703 Street City or Town Zip Code
4.	TELEPHONE: 508 2227555 FAX: 508 226 2218
5.	RENEWAL LICENSE: Date current license expires June 14, 2011
6.	SERVICES (check all that apply)
	Medical Substance Abuse Dental
	Surgical — Physical Rehabilitation — Mental Health —
	Birth Center Mobile Medical Transfusion
	Pharmacy Radiology (MRI) Limited Services
7.	NAME OF CLINIC ADMINISTRATOR:

Clinic Name	Four Women
Application Date	. 41711

Name of Clinic:		
Street:	Suite #/Floor	City/Zip.Code
Telephone Number:	Days and Hours o	f Operation:
Services offered:	· · · · · · · · · · · · · · · · · · ·	
Department of Public Safety Certifica	te Issued:	Fire Certificate Issued:
Substance Abuse Certificate Issued: -		•
Name of Clinic:		
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Cod
Telephone Number:	Days and Hours o	f Operation:
Services offered:		· · · · · · · · · · · · · · · · · · ·
Department of Public Safety Certifica	te Issued:	Fire Certificate Issued:
Substance Abuse Certificate Issued:		
Name of Clinic:		
rume of came.		
Street:	Suite #/Floor	City/Zip Cod
Telephone Number:	Days and Hours o	f Operation:
Services offered:		
· ·		

		Clinic Nam	e Four Women
	• •	Application	Date 417/11
	Number of patients per year: Less than 5,000		
10.	I certify under the penalties of perjury the returns and paid all state taxes required u		pelief, have filed all state tax
	rederal Identification Number		•
	Note: Your Federal Identification number determine whether you have met tax filin filing or tax payment obligations. Licens license suspension or revocation. This re	g or tax payment obligations. Lees who fail to correct their non	icensee who fail to correct their non- -filing or delinquency will be subject to
11.	Signature and Seal:		m · · · ·
	I, say that the statements contained in this if my knowledge.*	cense application are true, comp	y sworn on oath depose and plete and correct to the best of the last of the la
	•	75	
r		By: Corporate Office	er (if applicable)
Sub	scribed and sworn to before me on this	all day of April	20 <u></u>
Му	commission expires on March F	5 H	_20 <u>15</u> .
\	ary Public Co	(Seal)  SETH J WILLIAMS  Notary Public  mmonwealth of Massachusetts  mission Expires March 5, 2015  lication must be kept current.	