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

RECEIVED MAY 28 2019 MA Dept. of Public Health 99 Chauncy Street Boston, MA. 02111

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 5/20/19

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE: Four Women Health Services

2. NAME OF CLINIC: Same
(if same, write same)

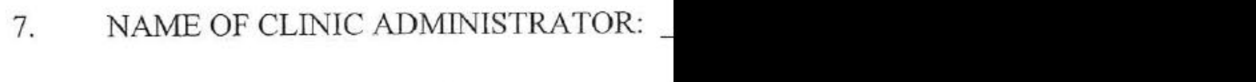
3. ADDRESS: 150 Emory St (Street) Attleboro (City or Town) 02703 (Zip Code)

4. TELEPHONE: 508.222.7555 EMAIL: FWHS7555@gmail.com

5. LICENSE NUMBER: 44H1 Date current license expires: 6/14/19

6. SERVICES (check all that apply)

Medical ✓	Substance Abuse ____	Dental ____
Surgical ✓	Physical Rehabilitation ____	Mental Health ____
Birth Center ____	Mobile Medical ____	Transfusion ____
Pharmacy ____	Limited Services ____	



7. NAME OF CLINIC ADMINISTRATOR: [redacted]

N/A

Clinic Name ____________

Application Date ____________

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: ____________

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________

2. Name of Clinic: ____________

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________

3. Name of Clinic: ____________

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women Health Services

Application Date 5/20/19

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.

[redacted] ________
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 <u>will be subject to license suspension or revocation</u>. This request is made under the authority of Mass. G. L. c.62C s.49A:

11. <u>Signature and Seal</u>:

I, [redacted], being first du[redacted] say that the statements contained in this license applicat[redacted] my knowledge.*

[redacted]
Sig[redacted] act in behalf of the Individual Applicant) or Corporate Name

By: ________________________
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 23 day of May 20 19.

My commission expires on 8/13/2021 20 21.

[signature]
Notary Public

(Seal)

*Note: All information contained in this application must be kept curr[ent]

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

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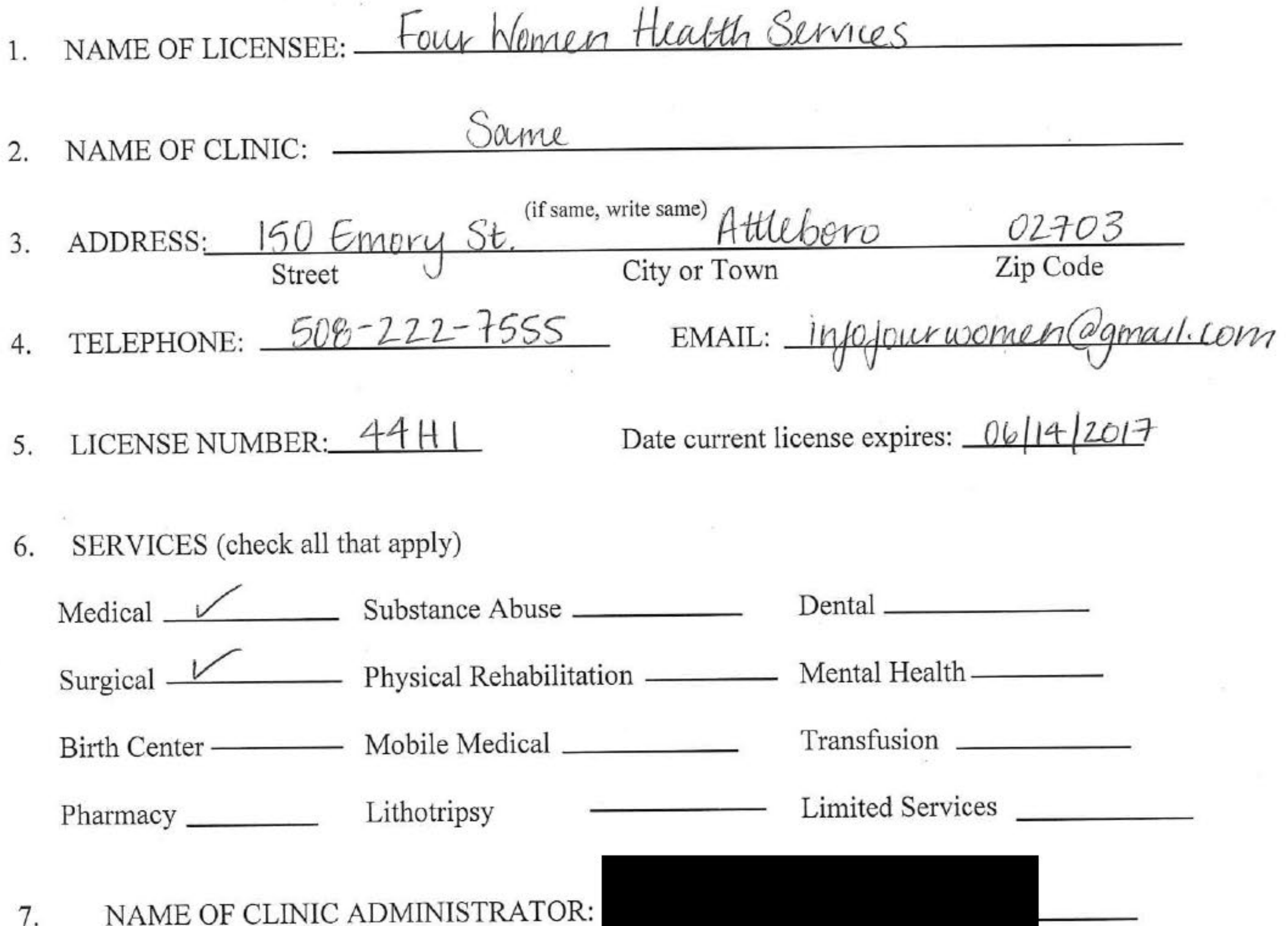
APR 26 2017
MA Dept of Public Health
99 Chauncy Street
Boston, MA 02111

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 04/20/2017

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.



1. NAME OF LICENSEE: Four Women Health Services
2. NAME OF CLINIC: Same (if same, write same)
3. ADDRESS: 150 Emory St. (Street) Attleboro (City or Town) 02703 (Zip Code)
4. TELEPHONE: 508-222-7555 EMAIL: info@fourwomen@gmail.com
5. LICENSE NUMBER: 44H1 Date current license expires: 06/14/2017
6. SERVICES (check all that apply)

Medical ✓	Substance Abuse ____	Dental ____
Surgical ✓	Physical Rehabilitation ____	Mental Health ____
Birth Center ____	Mobile Medical ____	Transfusion ____
Pharmacy ____	Lithotripsy ____	Limited Services ____

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Four Women Health Services

Application Date 04/20/2017

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: __________ Days and Hours of Operation: __________

Services offered: ____________________

Department of Public Safety Certificate Issued: __________ Fire Certificate Issued: __________

Substance Abuse Certificate Issued: __________

2. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: __________ Days and Hours of Operation: __________

Services offered: ____________________

Department of Public Safety Certificate Issued: __________ Fire Certificate Issued: __________

Substance Abuse Certificate Issued: __________

3. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: __________ Days and Hours of Operation: __________

Services offered: ____________________

Department of Public Safety Certificate Issued: __________ Fire Certificate Issued: __________

Substance Abuse Certificate Issued: __________

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women Health Services

Application Date 04/20/2017

9. Number of patients per year:
   Less than 5,000 X
   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.

[redacted] ________
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 <u>will be subject to license suspension or revocation</u>. This request is made under the authority of Mass. G. L. c.62C s.49A.

11. <u>Signature and Seal</u>:

I, [redacted] ________, being first duly sworn on oath depose and say that the statements contained in this license applica[redacted]of my knowledge.*

[redacted] ________
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

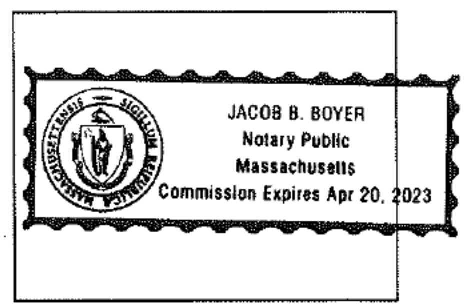
By: ________
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 20 day of April 20 17.

My commission expires on April 20 20 23.

____
Notary Public

(Seal)



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

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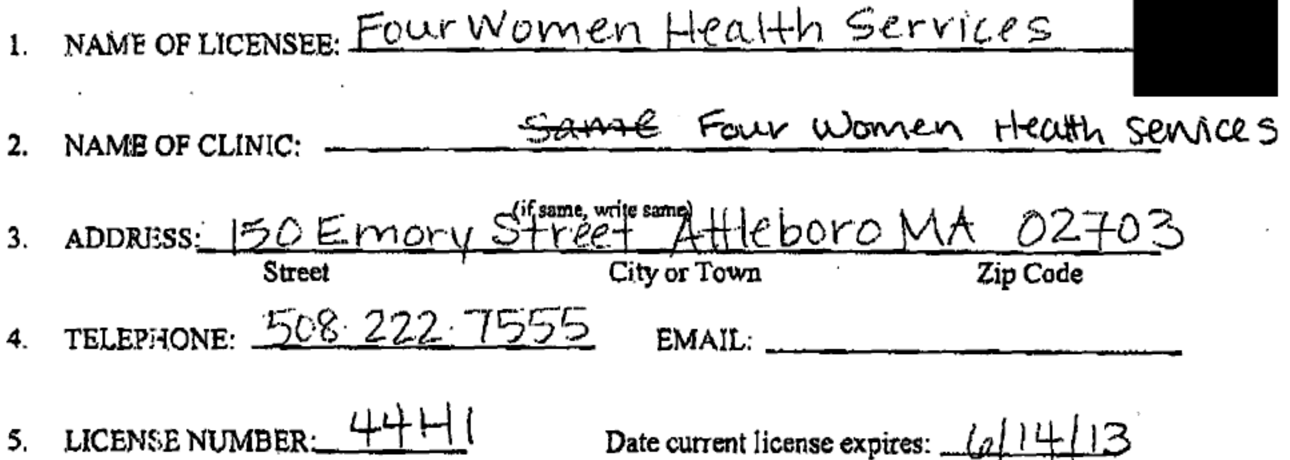
99 Chauncy St.
Boston, MA 02111

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

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/4/13

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.



4/1/13

1. NAME OF LICENSEE: Four Women Health Services [redacted]
2. NAME OF CLINIC: ~~Same~~ Four Women Health Services
   (if same, write same)
3. ADDRESS: 150 Emory Street (Street) Attleboro (City or Town) MA 02703 (Zip Code)
4. TELEPHONE: 508 222 7555 EMAIL: ______
5. LICENSE NUMBER: 44H1 Date current license expires: 6/14/13
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: [redacted]

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99 Chauncy Street
Boston, MA. 02111

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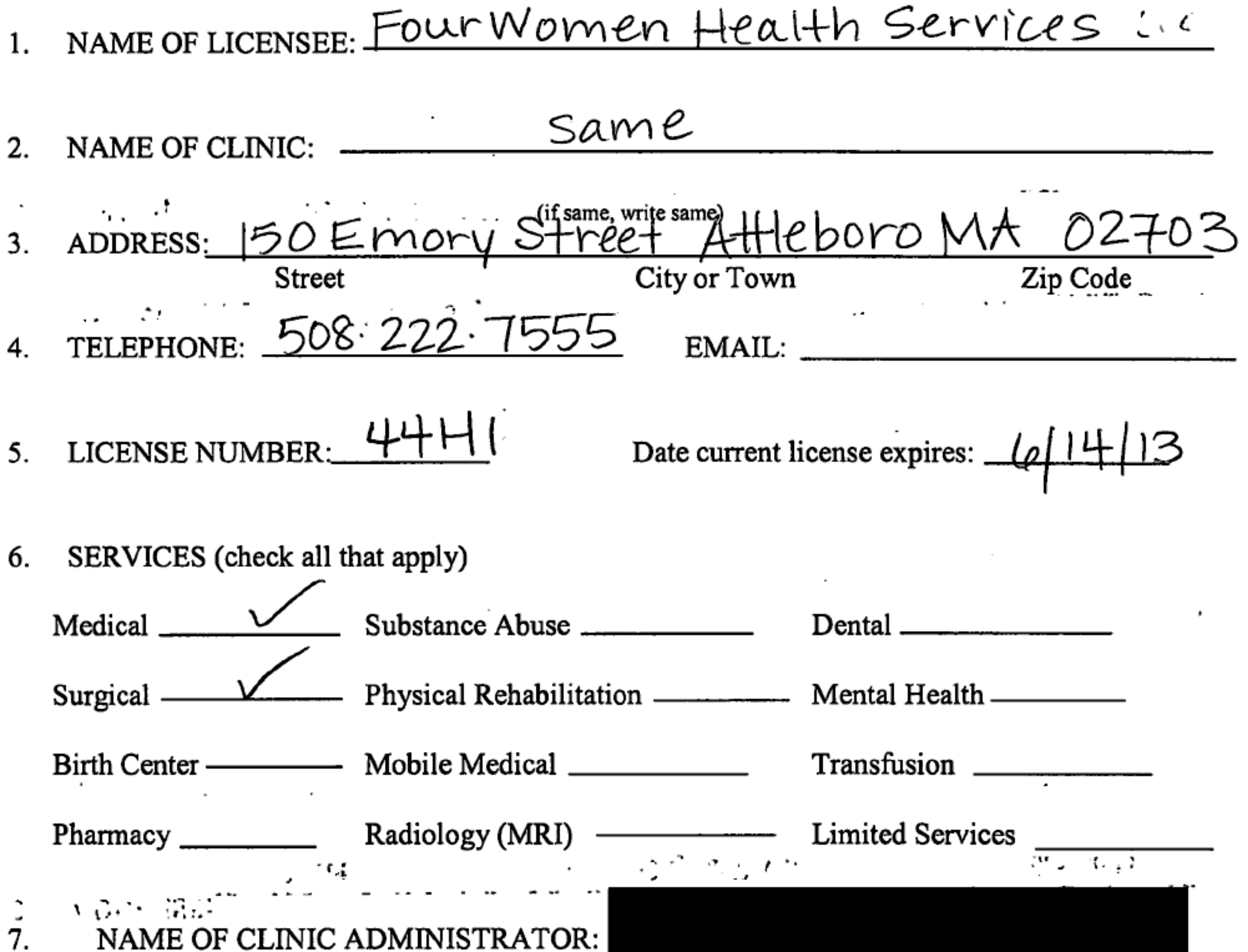
APR 29 2013
MA Dept. of Public Health
99 Chauncy St.
Boston, MA 02111

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

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/4/13

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.



1. NAME OF LICENSEE: Four Women Health Services LLC
2. NAME OF CLINIC: same (if same, write same)
3. ADDRESS: 150 Emory Street (Street) Attleboro MA (City or Town) 02703 (Zip Code)
4. TELEPHONE: 508·222·7555 EMAIL: ____
5. LICENSE NUMBER: 44H1 Date current license expires: 6/14/13
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: [redacted]

Clinic Name ____________________

Application Date ____________________

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: ____

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________________ Days and Hours of Operation: ____________________

Services offered: ____

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________________

2. Name of Clinic: ____

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________________ Days and Hours of Operation: ____________________

Services offered: ____

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________________

3. Name of Clinic: ____

____
Street: Suite #/Floor City/Zip Code

Telephone Number: ____________________ Days and Hours of Operation: ____________________

Services offered: ____

Department of Public Safety Certificate Issued: ____________ Fire Certificate Issued: ____________

Substance Abuse Certificate Issued: ____________________

(Attach addendum for additional sites, if applicable)

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women Health Services

Application Date 4/4/13

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:

________, being first duly sworn on oath depose and say that the statements contained in this license application are true, complete and correct to the best of my knowledge.*

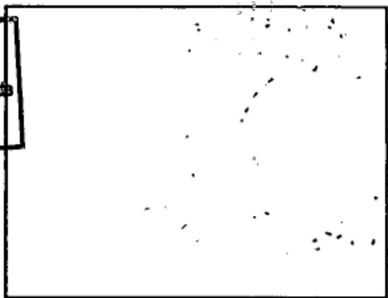
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

By: ________
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 17 day of April 20 13.

My commission expires on 11/10/2017 20 17.

________ (Seal)
Notary Public



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

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

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4.15.09

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE: [redacted]

2. NAME OF CLINIC: FOUR WOMEN HEALTH SERVICES

3. ADDRESS: 150 EMORY ST. (if same, write same) ATTLEBORO, MA 02703
   Street / City or Town / Zip Code

4. TELEPHONE: (508) 222-7555 FAX: (508) 226-2218

5. LICENSE TYPE:

   RENEWAL LICENSE: X Date current license expires 6/14/09

6. SERVICES (check all that apply)

Medical	✓	Substance Abuse		Dental	
Surgical	✓	Physical Rehabilitation		Mental Health	
Birth Center		Mobile Medical		Transfusion	
Pharmacy		Radiology (MRI)			

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2009 MAY -5 PM 9:39
HEALTH CARE QUALITY

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name FOUR WOMEN HEALTH SERVICES

Application Date 4.15.09

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: ~ NONE ~

Street: Suite #/Floor City/Zip Code

Telephone Number: ______ Days and Hours of Operation: ______

Services offered: ______

Department of Public Safety Certificate Issued: ______ Fire Certificate Issued: ______

Substance Abuse Certificate Issued: ______

2. Name of Clinic: ______

Street: Suite #/Floor City/Zip Code

Telephone Number: ______ Days and Hours of Operation: ______

Services offered: ______

Department of Public Safety Certificate Issued: ______ Fire Certificate Issued: ______

Substance Abuse Certificate Issued: ______

3. Name of Clinic: ______

Street: Suite #/Floor City/Zip Code

Telephone Number: ______ Days and Hours of Operation: ______

Services offered: ______

Department of Public Safety Certificate Issued: ______ Fire Certificate Issued: ______

Substance Abuse Certificate Issued: ______

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women Health Services

Application Date 4.15.09

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.

    ____
    Social Security Number (Voluntary)
    or Federal Identification Number

    Note: Your social security 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:

________________________, being first duly sworn on oath depose and say that the statements contained in this license application ________________________ my knowledge.*

____
Signature of Applicant (Individual or Person authorized to act in behalf of the Individual Applicant) or Corporate Name

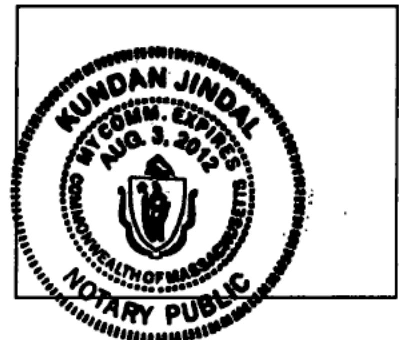
By ________________________
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 30th day of April 2009.

My commission expires on Aug. 3, 2012.

kjindal
Notary Public 4-30-09.

(Seal)



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

Clinic Name Four Women

Application Date 2.23.07

8. NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE:

SATELLITES:

1. Name of Clinic: None

   Street: Suite #/Floor City/Zip Code

   Telephone Number: Days and Hours of Operation:

   Services offered:

   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)

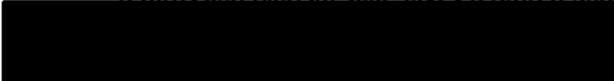
Clinic Name Four Women

Application Date 2.23.07

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.

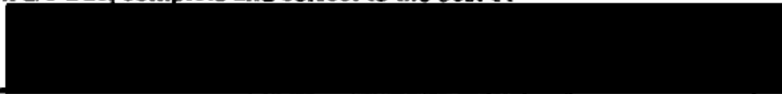


Social Security Number (Voluntary)
or Federal Identification Number

Note: Your social security 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:

______, being first duly sworn on oath depose and say that the statements contained in this license application are true, complete and correct to the best of my knowledge.*



Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

Bristol County Massachusetts
Before me the undersigned notary public personally appeared proved with a Massachusetts drivers license

By: ______
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 23rd day of February 19 2007.

My commission expires on December 29 19 2011.

Deborah J Davy (Seal)
Notary Public

Deborah J. Davy
Notary Public
Commonwealth of Massachusetts
My Commission Expires
December 29, 2011

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

HEALTH CARE QUALITY
2007 FE 26 AM 8:51
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COMMONWEALTH OF MASSACHUSETTS
Department of Public Health
DIVISION OF HEALTH CARE QUALITY
99 Chauncy Street
BOSTON, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 2.23.07

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE Four Women, Inc

2. NAME OF CLINIC Four Women
(if same, write same)

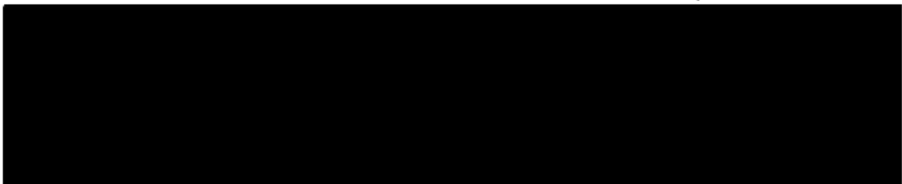
3. ADDRESS 150 Emory Street, Attleboro, MA 02703
Street City or Town Zip Code

4. TELEPHONE 508.222.7555

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 

DPHCQ 136
Rev. 10/05/05

Clinic - 44H1
ASC - A052

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

HEALTH CARE QUALITY
2007 JUN 14 AM 9: 11
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APPLICATION FOR CLINIC LICENSE

DATE: 6/1/07

In accordance with the "Regulations for the Licensure of Clinics, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Sections 51 and 56.

1. **NAME OF APPLICANT** Four Women Health Services LLC
2. **NAME OF CLINIC** Four Women ~~Health Services, LLC~~ (if same, write same)
3. **ADDRESS** 150 Emory St, Attleboro, MA 02703 (Street) (City/Town) (Zip Code)
4. **TELEPHONE** 508 222 7555
5. **LICENSE TYPE:**

(A) RENEWAL LICENSE: ______ Date current License expires ______

(B) ORIGINAL LICENSE: ______

(a) Initial Establishment: ______ Projected opening date: ______

(b) Change of Location: ______ Projected opening date: ______

(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 MAINTAINED UNDER LICENSE:**
(use separate sheet if necessary)

8. **NAME OF CLINIC ADMINIST**

Clinic Name Four Women Health Services, LLC

Application Date 6/1/07

9. **PLEASE CHECK CATEGORY 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)
f) ____________ Other (specify exact nature) ____________

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

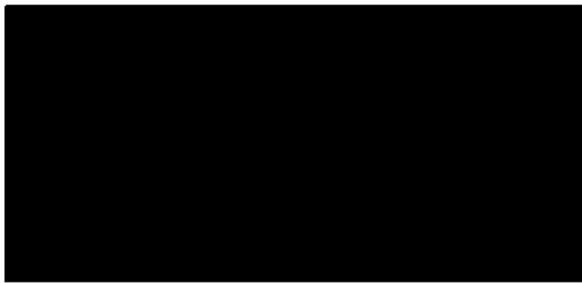
a) If the applicant is an individual, partnership or trust, the names and ownership percentages of such individual, partners or trustees, except that, in the case of a limited partnership, such information shall be provided only for each general partner and those limited partners owning five per cent or more of the partnership interest.

b) 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.



President 100%

100%

Clinic Name Four Women Health Service, LLC

Application Date 6/1/07

11. RESPONSIBILITY AND SUITABILITY

a) Has the applicant* owned stock or a partnership interest of 5% or more of; served a member, director, officer or administrator of; acted as a guarantor or co-signed for the debts of; or loaned money to, any health care facility that has been the subject of a bankruptcy petition?

Yes ______ No ✓

If yes, describe:

b) Has applicant*, or any of its officers, directors, or its clinic administrator ever been indicted or formally charged with any criminal offense?

Yes ______ No ✓

If yes, was the applicant or clinic administrator convicted, or did he/she plead guilty, plead nolo contendere, or admit facts in a judicial proceeding sufficient for a finding of guilt, in response to those charges?

Yes ______ No ______

If the answer to the second question is yes, explain, including the nature of the charges, the jurisdiction(s) in which they were brought, docket number(s), and the outcome of the proceedings:

c) Has the applicant* owned stock or a partnership interest of 5% or more; or served as a member, director, officer or administrator of any health care facility which has been the subject of proceedings in Massachusetts or any other jurisdiction to limit, suspend, revoke, refuse or grant, or refuse to renew the facility's license, Medicare certification, or Medicaid certification?

Yes ______ No ✓

If yes, describe:

* 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.

Clinic Name Four Women Health Services, LLC

Application Date 6/1/07

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 02703
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** [redacted] **aw.** Fed ID Four Women Health Services, LLC

Social Security Number (Voluntary)
or Federal Identification Number [redacted]

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.

15. **SIGNATURE and SEAL**

a) I, [redacted], being first duly sworn on oath depose and say that the statements contained in this license application are tr[redacted]

[redacted]

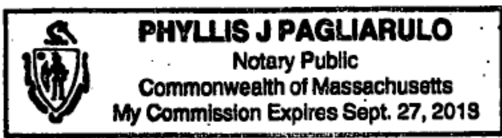
Signature of Applicant (Individual or Person authorized to act in behalf of the Individual Applicant) or Corporate Name [redacted] Services, LLC

By: [redacted]

Subscribed and sworn to before me on this 13th day of June, 2007.

My commission expires on Sept. 27, 2013.

[signature] (Seal)
Notary Public



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

(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, 2nd Floor, Boston, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/7/11

In accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby applies for a license to establish and/or maintain a clinic at the premises set forth below under provisions of the General Laws, Chapter 111, Section 51 and 56.

1. NAME OF LICENSEE: Four Women Health Services

2. NAME OF CLINIC: same

3. ADDRESS: 150 Emory St (if same, write same) Attleboro MA 02703
   Street / City or Town / Zip Code

4. TELEPHONE: 508 2227555 FAX: 508 2262218

5. LICENSE TYPE:

   RENEWAL LICENSE: 44H1 Date current license expires June 14, 2011

6. SERVICES (check all that apply)

APR 11 2011

Medical ✓	Substance Abuse ____	Dental ____
Surgical ✓	Physical Rehabilitation ____	Mental Health ____
Birth Center ____	Mobile Medical ____	Transfusion ____
Pharmacy ____	Radiology (MRI) ____	Limited Services ____

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Four Women

Application Date 4/7/11

8. NAME AND ADDRESS OF ALL **SATELLITE** LOCATIONS MAINTAINED UNDER LICENSEE:

1. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________________

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ________

Substance Abuse Certificate Issued: ____________

2. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________________

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ________

Substance Abuse Certificate Issued: ____________

3. Name of Clinic: ____________________

Street: Suite #/Floor City/Zip Code

Telephone Number: ____________ Days and Hours of Operation: ____________

Services offered: ____________________

Department of Public Safety Certificate Issued: ________ Fire Certificate Issued: ________

Substance Abuse Certificate Issued: ____________

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women

Application Date 4/7/11

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:

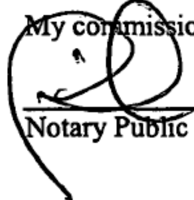
I, ________, being first duly sworn on oath depose and say that the statements contained in this license application are true, complete and correct to the best of my knowledge.*

Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

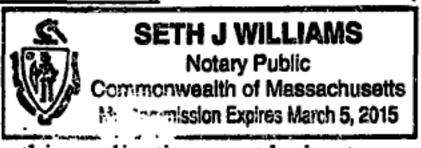
By: ________
Corporate Officer (if applicable)

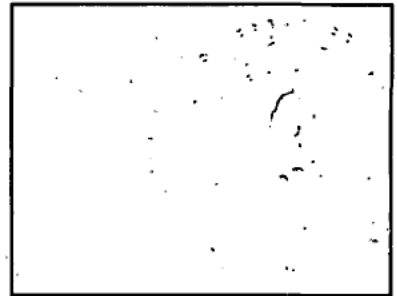
Subscribed and sworn to before me on this 6th day of April 20 11.

My commission expires on March 5th 20 15.



________ (Seal)
Notary Public





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