## COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Public Health

Department of Public Health

Division of Health Care Facility Licensure & Certification 99 Chauncy Street, 11th Floor, Boston, MA 02111-1212 (617) 753-8000

## APPLICATION FOR CLINIC LICENSE RENEWAL

			Date:	20.17	
app	accordance with the "Regu plies for a license to establi he General Laws, Chapter	ish and/or maintain a c	clinic at the pro	05 CMR 140", the emises set forth be	undersigned hereby low under provisions
1.	NAME OF LICENSEE:	Women's He	alth Serv	ices, P.C.	ECEIVE
2.	NAME OF CLINIC: —				OCT 1 9 2017  MA Dept. of Public Health 99 Chauncy Street
3.	ADDRESS:	vard Stret (if same, v	City or Town	, m\	Roston, MA 02111  Lip Code
4.	TELEPHONE: (617)	277- 6009	EMAIL:	<u> </u>	partners.org
5.	LICENSE NUMBER:_	1304	Date current 1	icense expires:	1. 23.17
6.	SERVICES (check all the	nat apply)			
	Medical	Substance Abuse		Dental	<del></del>
	Surgical — V	Physical Rehabilitatio	on	Mental Health —	
	Birth Center ———	Mobile Medical		Transfusion	
	Pharmacy	Lithotripsy —		Limited Services	3
7.	NAME OF CLINIC A	ADMINISTRATOR:			

Clinic Name Women's Health Services, P.C.

Application Date 9. 20. 17		Application Date	9	20.	17
----------------------------	--	------------------	---	-----	----

Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	ation:
Services offered:		
Department of Public Safety Cer	tificate Issued: Fire C	ertificate Issued:
Substance Abuse Certificate Issu	ned:	
2.5		
Name of Clinic:	3	
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	ation:
Services offered:		
Department of Public Safety Cer	rtificate Issued: Fire C	ertificate Issued:
Substance Abuse Certificate Issu	ued:	
Name of Clinic: ————		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	ation:
Services offered:		

Rev. 03/25/13

	Application Date9. 20. 17
9.	Number of Outpatients visits per year:  Less than 5,000  5,000 - 25,000  25,000 - 100,000  100,000
	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.
	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 of Person authorized act in behalf of the Individual Applicant) or Corporate Name
	By: Corporate Officer (if applicable)
Sub	bscribed and sworn to before me on this 10 day of Ochbec 20 2017.
Му	commission expires on January 19 20 18.
Not	tary Public (Seal)
*No	ote: All information contained in this application must be kept current.
	KRISTEN P. KOCH  Notary Public  Commonwealth of Massachusetts  My Commission Expires  January 19, 2018

Clinic Name Women's Yearth Services, P. C.

## COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Public Health

Division of Health Care Facility Licensure and Certification 99 Chauncy Street, 11th Floor, Boston, MA 02111-1212 (617) 753-8000

## APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 12. 27. 16

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:	Women's Health Se	ervices, P.C.			
2.	NAME OF CLINIC: —	Same				
3.	ADDRESS: III Va	(if same, write same)  City or Tov	wn Zip Code			
4.	TELEPHONE: (417)2	77- 8009 EMAI	L: partners org			
5.	LICENSE NUMBER:	A 3 0 4 Date curren	nt license expires:			
6.	SERVICES (check all the	nat apply)				
	Medical	Substance Abuse	Dental			
	Surgical	Physical Rehabilitation	Mental Health			
	Birth Center ———	Mobile Medical	Transfusion			
	Pharmacy	Lithotripsy ————	Limited Services			
7.	NAME OF CLINIC	ADMINISTRATOR: _				

Women's Health Services, f.C. Clinic Name Application Date 12. 27. 16

Name of Chine.	8				
Street:	Suite #/Floor	City/Zip Code			
Telephone Number:	Days and Hours of Opera	ation:			
Services offered:					
Department of Public Safety Cer	rtificate Issued: Fire C	Certificate Issued:			
Substance Abuse Certificate Issu	ued:				
Name of Clinic:					
Street:	Suite #/Floor	City/Zip Code			
Telephone Number:	Days and Hours of Oper	ration:			
Services offered:					
Department of Public Safety Ce	rtificate Issued: Fire C	Certificate Issued:			
Substance Abuse Certificate Iss	ued:				
Name of Clinic: —					
Street:	Suite #/Floor	City/Zip Cod			
Telephone Number:	Days and Hours of Open	ration:			

i									
ı	Affach	addendum	tor	additional	Sites	11	ann	licah	e
٩	1 Ittucii	uddelidaili	LUI	additional	DILLOS,		upp	nouv	

(Material additional for additional files, if approache)	Clinic Name Women's Health Servius, P.C.
	Application Date 12.27.16
9. Number of Outpatients visits per year:  Less than 5,000 ———  5,000 – 25,000 ————  25,000 – 100,000 ————  100,000 -	
I certify under the penalties of perjury that I, to n returns and paid all state taxes required under law rederar identification number	
Note: Your Federal Identification number will be determine whether you have met tax filing or tax filing or tax payment obligations. Licensees who	be furnished to the Massachusetts Department or Revenue to payment obligations. Licensee who fail to correct their non-fail to correct their non-filing or delinquency will be subject to made under the authority of Mass. G. L. c.62C s.49A.
11. Signature and Seal:	
I,say that the statements contained in this needse apmy knowledge.*	, being first duly sworn on oath depose and princation are true, complete and correct to the best of  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 27	Λ 1 ± 1/.
My commission expires on	20 18
Notary Public	(Seal)
*Note: All information contained in this application	must be kept current.
KRISTEN P. 1 Notary Put Commonwealth of N My Commission January 19,	blic Bassachusetts Expires

Rev. 07/01/14