COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
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: 9.20.17

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.

RECEIVED
OCT 19 2017
MA Dept. of Public Health
99 Chauncy Street
Boston, MA 02111

1. NAME OF LICENSEE: Women's Health Services, P.C.

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

3. ADDRESS: 111 Harvard Street (Street) Brookline, MA (City or Town) 02446 (Zip Code)

4. TELEPHONE: (617) 277-0009 EMAIL: [redacted]@partners.org

5. LICENSE NUMBER: A304 Date current license expires: 11.23.17

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 Women's Health Services, P.C.

Application Date 9.20.17

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 Women's Health Services, P.C.

Application Date 9.20.17

9. Number of Outpatients visits 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 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:

[redacted], 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.*

[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 16 day of October 20 2017.

My commission expires on January 19 20 18.

Kristen P. Koch
Notary Public

(Seal)

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

KRISTEN P. KOCH
Notary Public
Commonwealth of Massachusetts
My Commission Expires
January 19, 2018

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 Services, P.C.

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

3. ADDRESS: 111 Harvard Street (Street) Brookline, MA (City or Town) 02446 (Zip Code)

4. TELEPHONE: (617)277-0009 EMAIL: [redacted] partners.org

5. LICENSE NUMBER: A304 Date current license expires: _____

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 Women's Health Services, P.C.

Application Date 12.27.16

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 Women's Health Services, 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 - _____

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 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, [redacted], 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.*

[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 27 day of December 20 16.

My commission expires on January 19 20 18.

Kristen P. Koch
Notary Public

(Seal)

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

KRISTEN P. KOCH
Notary Public
Commonwealth of Massachusetts
My Commission Expires
January 19, 2018