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: 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: 4411 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 5/29/19

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.

   260193670
   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 applicat[redacted] 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 23 day of May 20 19.

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

Ami Rostami
Notary Public

(Seal)

ARIA-BARZAN ROSTAMI
Notary Public, Commonwealth of Massachusetts
My Commission Expires August 13, 2021

*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, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

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

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

4. TELEPHONE: 508-222-7555 EMAIL: infofourwomen@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 ✓
   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.

   260193670
   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 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)

JACOB B. BOYER
Notary Public
Massachusetts
Commission Expires Apr 20, 2023

*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, 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 [redacted] 4/1/13

2. NAME OF CLINIC: ~~Same~~ Four Women Health Services

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

4. TELEPHONE: 508 222 7555 EMAIL: _____

5. LICENSE NUMBER: 4411 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]

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 Inc

2. NAME OF CLINIC: same

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

4. TELEPHONE: 508·222·7555 EMAIL: _____

5. LICENSE NUMBER: 4411 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.

260193943
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 17 day of April 20 13.

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

Krista L. Rivet
Notary Public

(Seal)

KRISTA LYN RIVET
Notary Public, Commonwealth of Massachusetts
My Commission Expires November 10, 2017

*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) ____	

RECEIVED
2009 MAY -5 P 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.

   26 0193943
   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:

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

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

By [redacted]
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)

KUNDAN JINDAL
MY COMM. EXPIRES AUG. 3, 2012
COMMONWEALTH OF MASSACHUSETTS
NOTARY PUBLIC

*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.

04.3403912
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:

[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

Bristol County Massachusetts
Before me the undersigned notary public personally appeared [redacted] 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.

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

HEALTH CARE QUALITY
2007 FE 26 AM 8:51
RECEIVED

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 [redacted]

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

APPLICATION FOR CLINIC LICENSE

DATE: 6/1/07

RECEIVED

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 [redacted]

2. NAME OF CLINIC ~~Four Women Health Services, LLC~~
(if same, write same)

3. ADDRESS 150 Emery 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 [redacted]

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.

[redacted] 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 Robbins 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. Four ID Four Women Health Services, LLC
[redacted] 26-0193443

Social Security Number (Voluntary)
or Federal Identification Number SS# [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.

Notary Public (Seal)

PHYLLIS J PAGLIARULO
Notary Public
Commonwealth of Massachusetts
My Commission Expires Sept. 27, 2013

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: 4/7/11

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: 508 226 2218

5. LICENSE TYPE:
   RENEWAL LICENSE: 4HI 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.

~~185150097~~ 9 260193670
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 6th day of April 20 11.

My commission expires on March 5th 20 15.

_____ (Seal)
Notary Public

SETH J WILLIAMS
Notary Public
Commonwealth of Massachusetts
My Commission Expires March 5, 2015

*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, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 4/22/2019

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: Planned Parenthood League of Massachusetts, Inc.

2. NAME OF CLINIC: Planned Parenthood League of Massachusetts

3. ADDRESS: 1055 Commonwealth Ave. Boston 02215 (if same, write same)
   Street City or Town Zip Code

4. TELEPHONE: 617-616-1600 EMAIL: [redacted]@pplm.org

5. LICENSE NUMBER: 4174 Date current license expires: 6-23-19

RECEIVED
APR 23 2019
MA Dept. of Public Health
99 Chauncy Street
Boston, MA 02111

6. SERVICES (check all that apply)

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

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Planned Parenthood League of Massachusetts

Application Date 4/22/2019

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Central MA center

470 Pleasant St. Worcester, 01609
Street: Suite #/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

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

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of Massachusetts - Western MA center

3550 Main St. Ste. 201 Springfield, MA 01107
Street: Suite #/Floor City/Zip Code

Telephone Number: 413-732-1620 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

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

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: Planned Parenthood League of Massachusetts - Fitchburg

391 Main St. Fitchburg, 01420
Street: Suite #/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: see attached

Services offered: Medical

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

Substance Abuse Certificate Issued: N/A

Clinic Name Planned Parenthood League of Massachusetts

Application Date 4/22/2019

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Marlborough

91 Main St. Ste. 103 Marlborough, 01752
Street: Suite #/Floor City/Zip Code

Telephone Number: 508-884-3300 Days and Hours of Operation: See attached

Services offered: Medical

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

Substance Abuse Certificate Issued: N/A

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: _____

Planned Parenthood League of Massachusetts, Inc.
Days & Hours of Operation

Greater Boston Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	7:30am	7:30am	7:30am	7:30am	7:30am	7:30am	--
Close	7:00pm	7:00pm	7:00pm	7:00pm	7:00pm	3:00pm	--

Central MA Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	8:00am	8:00am	8:00am	8:00am	8:00am	8:00am	--
Close	7:15pm	3:45pm	7:15pm	7:15pm	5:00pm	2:00pm	--

Western MA Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	8:00am	8:00am	7:45am	8:00am	7:45am	--	--
Close	5:00pm	7:30pm	5:00pm	7:30pm	5:00pm	--	--

Fitchburg Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	10:00am	10:00am	--	10:00am	--	--	--
Close	4:00pm	7:30pm	--	7:30pm	--	--	--

Marlborough Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	--	--	10:00am	--	10:00am	8:00am	--
Close	--	--	7:30pm	--	4:00pm	1:00pm	--

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood League of Massachusetts

Application Date 4/22/2019

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.

04-2698497
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 person authorized act in behalf of Corporate Name

By: _____
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 22nd day of April 2019.

My commission expires on 23rd day of September 2022.

Max Tendler
Notary Public

(Seal)

MAX TENDLER
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES SEPTEMBER 23, 2022

*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, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: 6-22-17

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.

1. NAME OF LICENSEE: Planned Parenthood League of Massachusetts, Inc.

2. NAME OF CLINIC: Planned Parenthood League of Massachusetts

3. ADDRESS: 1055 Commonwealth Ave (if same, write same) Boston 02215
   Street City or Town Zip Code

4. TELEPHONE: 617-616-1600 EMAIL [redacted]@pplm.org

5. LICENSE NUMBER: 4174 Date current license expires: 6-23-17

6. SERVICES (check all that apply)

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

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Planned Parenthood League of Massachusetts, Inc.

Application Date 6-22-17

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Central MA center

470 Pleasant St — Worcester, MA 01609
Street: Suite #/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

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

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of Massachusetts - Western MA Center

3550 Main St Ste 201 — Springfield, MA 01107
Street: Suite #/Floor City/Zip Code

Telephone Number: 413-732-1620 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

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

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: Planned Parenthood League of Massachusetts - Fitchburg

391 Main St — Fitchburg, MA 01420
Street: Suite #/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: See attached

Services offered: Medical

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

Substance Abuse Certificate Issued: N/A

Clinic Name Planned Parenthood League of Massachusetts, Inc.

Application Date 6-22-17

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Marlborough

91 Main St Ste 103 Marlborough, MA 01752

Street: Suite #/Floor City/Zip Code

Telephone Number: 508-884-3300 Days and Hours of Operation: See attached

Services offered: Medical

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

Substance Abuse Certificate Issued: N/A

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: _____

Greater Boston Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	7:30am	7:30am	7:30am	7:30am	7:30am	7:30am	--
Close	7:30pm	7:30pm	7:30pm	7:30pm	7:30pm	3:30pm	--

Central MA Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	8:00am	8:00am	8:00am	8:00am	8:00am	8:00am	--
Close	7:15pm	3:45pm	7:15pm	7:15pm	5:00pm	2:00pm	--

Western MA Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	8:00am	8:00am	7:45am	8:00am	7:45am	--	--
Close	5:00pm	8:00pm	5:00pm	8:00pm	5:00pm	--	--

Fitchburg Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	10:00am	10:00am	--	10:00am	--	--	--
Close	4:00pm	7:30pm	--	7:30pm	--	--	--

Marlborough Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	--	--	10:00am	--	10:00am	8:00am	--
Close	--	--	7:30pm	--	4:00pm	1:00pm	--

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood League of Massachusetts, Inc

Application Date 6-22-17

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.

04-2698497
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]
Signatu[redacted]ized act
in beha[redacted] Name

By: _____
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 22 day of June 20 17.

My commission expires on 23 September, 2022 20 _____.

Max Tendler
Notary Public

(Seal)

MAX TENDLER
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS
MY COMM. EXPIRES SEPTEMBER 23, 2022

*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, 11th Floor, Boston, MA 02111-1212
(617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: April 2, 2013

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: Planned Parenthood League of Massachusetts, Inc.

2. NAME OF CLINIC: Planned Parenthood League of Massachusetts / Preterm Health Services of Greater Boston
(if same, write same)

3. ADDRESS: 1055 Commonwealth Ave Boston 02215
Street City or Town Zip Code

4. TELEPHONE: 617-616-1600 EMAIL: [redacted]@pplm.org

5. LICENSE NUMBER: 4174 Date current license expires: 06/23/2013

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 Planned Parenthood League of MA, Inc.

Application Date 04/02/2013

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Central MA Center

470 Pleasant Street — Worcester, MA 01609
Street: Suite#/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: Please see attached document

Services Offered: Medical; Surgical

Department of Public Safety Certificate Issued: 11/15/2011 Fire Certificate Issued: 01/24/2013

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of Massachusetts - Western MA Center

3550 Main Street Suite 201 Springfield, MA 01107
Street: Suite#/Floor City/Zip Code

Telephone Number: 413-732-1620 Days and Hours of Operation: Please see attached document

Services Offered: Medical; Surgical

Department of Public Safety Certificate Issued: 05/02/2011 Fire Certificate Issued: 09/12/2012

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: Planned Parenthood League of Massachusetts - Milford

208 Main Street Commercial building, 1st floor Milford, MA 01757
Street: Suite#/Floor City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: Please see attached document

Services Offered: Medical

Department of Public Safety Certificate Issued: 04/24/13 Fire Certificate Issued: 06/03/2010

Substance Abuse Certificate Issued: N/A

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood League of MA, Inc.

Application Date 04/02/2013

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

1. Name of Clinic: Planned Parenthood League of Massachusetts - Fitchburg

391 Main Street | 1st Floor | Fitchburg, MA 01420
Street: | Suite#/Floor | City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: Please see attached document

Services Offered: Medical

Department of Public Safety Certificate Issued: 04/25/2013 Fire Certificate Issued: 07/20/2010

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of Massachusetts - Marlborough

91 Main Street | Suite 103 | Marlborough, MA 01752
Street: | Suite#/Floor | City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: Please see attached document

Services Offered: Medical

Department of Public Safety Certificate Issued: 04/24/2013 Fire Certificate Issued: 05/10/2010

Substance Abuse Certificate Issued: N/A

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 Planned Parenthood League of MA, Inc.

Application Date 04/02/13

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.

04-2698497
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 30th day of April 20 13.

My commission expires on June 7 20 13.

_____ (Seal)
Notary Public

Erin E. Gormley
Notary Public
Commonwealth of Massachusetts
My Commission Expires June 7, 2013

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

(R)

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

HEALTH CARE QUALITY
2011 AP 29 PM 2:31

RECEIVED

APPLICATION FOR CLINIC LICENSE RENEWAL

Date: April 27, 2011

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: Planned Parenthood League of MA

2. NAME OF CLINIC: Planned Parenthood League of MA

3. ADDRESS: 1055 Commonwealth Avenue (if same, write same) Boston, MA 02215
Street City or Town Zip Code

4. TELEPHONE: 617.616.1600 FAX: 617.616.1665

5. LICENSE TYPE:

RENEWAL LICENSE: X4174 Date current license expires 6/23/11

6. SERVICES (check all that apply)

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

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Planned Parenthood League of MA

Application Date April 27, 2011

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

1. Name of Clinic: Planned Parenthood League of MA

470 Pleasant Street — Suite #/Floor — Worcester/01609
Street: City/Zip Code

Telephone Number: 508-854-3300 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 11/12/~~2009~~ 2011 Fire Certificate Issued: 2/22/2011

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of MA

3550 Main Street — Suite 201 — Springfield/01107
Street: Suite #/Floor City/Zip Code

Telephone Number: 413-732-1620 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 5/26/~~2009~~ 2011 Fire Certificate Issued: 9/29/2010

Substance Abuse Certificate Issued: N/A

~~X~~3. Name of Clinic: Planned Parenthood League of MA - PLAN

260 Elm Street — Suite 109, Davis Square — Somerville/02144
Street: Suite #/Floor City/Zip Code

Telephone Number: 617-616-1600 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 5/25/13 Fire Certificate Issued: 5/2011

Substance Abuse Certificate Issued: N/A

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood League of MA

Application Date April 27, 2011

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

1. Name of Clinic: Planned Parenthood League of MA

91 Main Street — Suite #/Floor — Marlborough/01752
Street: City/Zip Code

Telephone Number: 508-970-1100 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 5/10/~~2010~~ 2012 Fire Certificate Issued: 5/10/2010

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of MA

208 Main Street — Suite #/Floor — Milford/01757
Street: City/Zip Code

Telephone Number: 508-458-3300 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 6/3/~~10~~ 2012 Fire Certificate Issued: 6/3/10

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: Planned Parenthood League of MA

391 Main Street — Suite #/Floor — Fitchburg/01420
Street: City/Zip Code

Telephone Number: 978-516-0900 Days and Hours of Operation: _____

Services offered: _____

Department of Public Safety Certificate Issued: 7/20/~~10~~ 2012 Fire Certificate Issued: 7/20/10

Substance Abuse Certificate Issued: N/A

(Attach addendum for additional sites, if applicable)

Addendum

Clinic Name Planned Parenthood League of MA

Application Date April 27, 2011

9. Number of patients per year:
   Less than 5,000 _____
   5,000 – 25,000 _____
   25,000 – 100,000 X
   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.

04-2698497
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]

Signatu[redacted]rized act
in beha[redacted] Name

By: _____
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 28th day of April 2011.

My commission expires on NOV 23 2017

Notary Public

(Seal).

LAURA KATZ LEACU
MY COMMISSION EXPIRES NOV. 3, 2017
NOTARY PUBLIC
COMMONWEALTH OF MASSACHUSETTS

*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: June 1 2009

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: Planned Parenthood League of MA

2. NAME OF CLINIC: Planned Parenthood League of MA

3. ADDRESS: 1055 Commonwealth Ave Boston MA 02215
(if same, write same)
Street City or Town Zip Code

4. TELEPHONE: 617 616 1600 FAX: 617 616 1675

5. LICENSE TYPE:

RENEWAL LICENSE: ✓ Date current license expires 6/23/09.

6. SERVICES (check all that apply)

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

7. NAME OF CLINIC ADMINISTRATOR: [redacted]

Clinic Name Planned Parenthood

Application Date 6/1/09

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

11. Name of Clinic: Planned Parenthood League of MA #4163

631 Lincoln St. Worcester, MA 01605
Street: Suite #/Floor City/Zip Code

Telephone Number: 508.854.3300 Days and Hours of Operation: M 8-5, T 830-4, W 830-730, Th 730-730, F 730-4, 9/6 SA 730-1

Services offered: Medical | Surgical

Department of Public Safety Certificate Issued: 2/20/10 Fire Certificate Issued: 4/21/09

Substance Abuse Certificate Issued: NA

12. Name of Clinic: Planned Parenthood League of MA #4132

3550 Main Street Suite 201 Springfield, MA 01107
Street: Suite #/Floor City/Zip Code

Telephone Number: 413.732.1620 Days and Hours of Operation: Mon 8-5, Tue 8-8, Wed, Th 7:45-8p, Fri 7:45-4p, Sat 7:45-1p

Services offered: Medical | Surgical

Department of Public Safety Certificate Issued: 5/26/09 Fire Certificate Issued: 8/18/08

Substance Abuse Certificate Issued: NA

13. Name of Clinic: Planned Parenthood League of MA

1055 Commonwealth Ave Boston MA 02215
Street: Suite #/Floor City/Zip Code

Telephone Number: 617-616-1600 Days and Hours of Operation: M, T, Th, F 7:30-7:15p, Wed 7:30-4p (2nd/4th), Wed 7:30-1pm (1st/3rd), Sat 7:30-4

Services offered: Medical | Surgical

Department of Public Safety Certificate Issued: 10/30/08 Fire Certificate Issued: 3/06/09

Substance Abuse Certificate Issued: N/A

(Attach addendum for additional sites, if applicable)

Clinic Name Planned Parenthood

Application Date 6/1/09

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.

042698497
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:

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.*

Planned Parenthood League of MA,

Signature of Applicant (Individual or Person authorized act in beha[redacted]e

By: [redacted]
Co[redacted]

Subscribed and sworn to before me on this 4 day of June 2009.

My commission expires on April 16 2015.

Jessica T. Saunders
Notary Public

(Seal)

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

JESSICA T. SAUNDERS
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires April 16, 2015

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: 4/9/2007

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 Planned Parenthood League of MA

2. NAME OF CLINIC Planned Parenthood | Preterm Health Services of Greater Boston
(if same, write same)

3. ADDRESS 1055 Commonwealth Ave Boston, MA 02215
Street City or Town Zip Code

4. TELEPHONE 617-616-1600

5. LICENSE TYPE:

(A) RENEWAL LICENSE ✓ Date current license expires 6/23/2007

Fee #: 1114

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 [redacted]

Clinic Name Planned Parenthood

Application Date 4/9/07

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

SATELLITES:

1. Name of Clinic: Planned Parenthood League of MA

631 Lincoln St — Worcester MA 01605
Street: — Suite #/Floor — City/Zip Code

Telephone Number (508) 854-3300 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

DPS Issued 3/2/2009 Fire Issued 1-16-2007

2. Name of Clinic: Planned Parenthood League of MA

3550 Main Street #201 — Springfield MA 01107
Street: — Suite #/Floor — City/Zip Code

Telephone Number: 413 732 1620 Days and Hours of Operation: See attached

Services offered: Medical, Surgical

DPS Issued 4/17/09 Fire Issued 8/30/2006

3. Name of Clinic: _____

_____
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 Planned Parenthood

Application Date 4/9/07

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.

042698497
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:

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.*

Planned Parenthood League of MA
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

By: [redacted]
Corp

Subscribed and sworn to before me on this 2nd day of April ~~19~~ 2007.

My commission expires on June 7 ~~19~~ 2007.

[redacted] (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
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.

04-3150652
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

3. ADDRESS: 111 Harvard Street (if same, write same) Brookline, MA 02446
   Street City or Town 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.

04-3150652
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