

**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

3. ADDRESS: 150 Emory St <sup>(if same, write same)</sup> Attleboro 02703  
Street City or Town 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: 

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 of 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 to my knowledge.\*

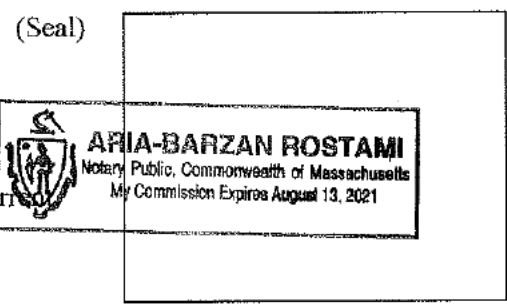
[Redacted Signature]  
Signature of Applicant (Individual or Person authorized to act in behalf of the Individual Applicant) or Corporate Name

By: \_\_\_\_\_  
Corporate Officer (if applicable)

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

My commission expires on 8/13/2021 20 21

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

MA Department of Public Health  
99 Chauncy Street  
Boston, MA 02111

RECEIVED  
APR 26 2017

**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: 

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   2    
 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 of 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 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

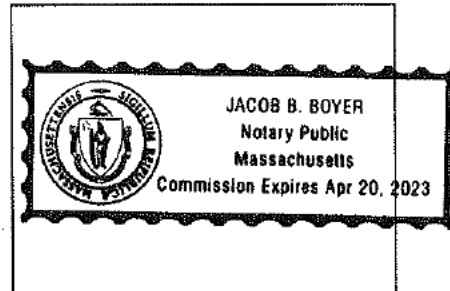
By: \_\_\_\_\_  
Corporate Officer (if applicable)

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

My commission expires on April 20 20 23.

Jacob B. Boyer  
Notary Public

(Seal)



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


**RECEIVED**  
**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

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

**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 
2. NAME OF CLINIC: SAME Four Women Health Services
3. ADDRESS: 150 Emory Street <sup>(if same, write same)</sup> Attleboro MA 02703  
Street City or Town Zip Code
4. TELEPHONE: 508.222.7555 EMAIL: \_\_\_\_\_
5. LICENSE NUMBER: 4441 Date current license expires: 6/14/13

6. SERVICES (check all that apply)
- |  |                               |                        |
|--|-------------------------------|------------------------|
| Medical <input checked="" type="checkbox"/>  | Substance Abuse _____         | Dental _____           |
| Surgical <input checked="" type="checkbox"/> | Physical Rehabilitation _____ | Mental Health _____    |
| Birth Center _____                           | Mobile Medical _____          | Transfusion _____      |
| Pharmacy _____                               | Radiology (MRI) _____         | Limited Services _____ |

7. NAME OF CLINIC ADMINISTRATOR: 

**RECEIVED**

RECEIVED  
APR 29 2013

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

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

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: 44H1 Date current license expires: 6/14/13

6. SERVICES (check all that apply)
- |  |                               |                        |
|--|-------------------------------|------------------------|
| Medical <input checked="" type="checkbox"/>  | Substance Abuse _____         | Dental _____           |
| Surgical <input checked="" type="checkbox"/> | Physical Rehabilitation _____ | Mental Health _____    |
| Birth Center _____                           | Mobile Medical _____          | Transfusion _____      |
| Pharmacy _____                               | Radiology (MRI) _____         | Limited Services _____ |

7. NAME OF CLINIC ADMINISTRATOR: 



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.

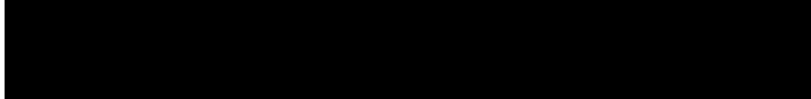
260193943  
Federal Identification Number

Note: Your Federal Identification number will be furnished to the Massachusetts Department of 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.\*



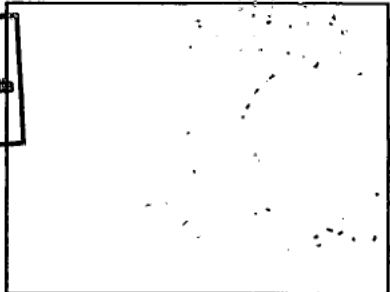
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

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.

Krista L. Rivet  
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, 2<sup>nd</sup> 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: 

2. NAME OF CLINIC: FOUR WOMEN HEALTH SERVICES

3. ADDRESS: 150 EMORY ST. <sup>(if same, write same)</sup> 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 <input checked="" type="checkbox"/>	Substance Abuse <input type="checkbox"/>	Dental <input type="checkbox"/>
Surgical <input checked="" type="checkbox"/>	Physical Rehabilitation <input type="checkbox"/>	Mental Health <input type="checkbox"/>
Birth Center <input type="checkbox"/>	Mobile Medical <input type="checkbox"/>	Transfusion <input type="checkbox"/>
Pharmacy <input type="checkbox"/>	Radiology (MRI) <input type="checkbox"/>	

RECEIVED  
2009 MAY - 5 PM 9:39  
HEALTH CARE QUALITY

7. NAME OF CLINIC ADMINISTRATOR: 

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.

26 019 3943  
Social Security Number (Voluntary)  
or Federal Identification Number

Note: Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or 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 to my knowledge.\*

\_\_\_\_\_  
in behalf of the Individual Applicant) or Corporate Name

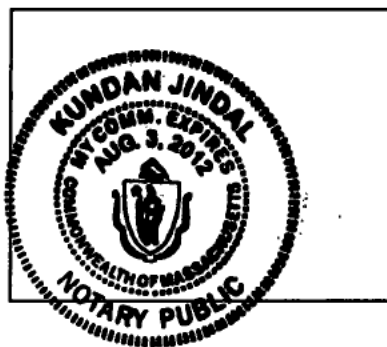
By \_\_\_\_\_  
Corporate Officer (if applicable)

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.

04-3403912

Social Security Number (Voluntary)  
or Federal Identification Number

Note: Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or 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 Signature]

\_\_\_\_\_, 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]

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 23<sup>rd</sup> 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 FEB 26 AM 8:51

RECEIVED

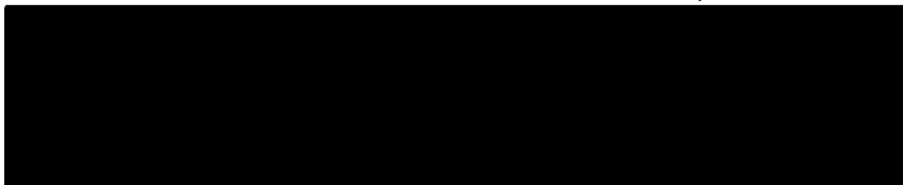
**APPLICATION FOR CLINIC LICENSE RENEWAL**

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





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  
2397 JR 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
- 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 ADMINISTRATOR  


Clinic Name Four Women Health Services, LLC

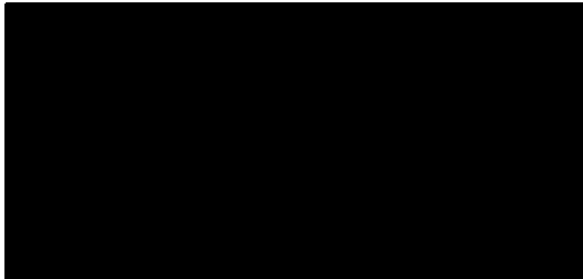
Application Date 6/1/07

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 Services 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

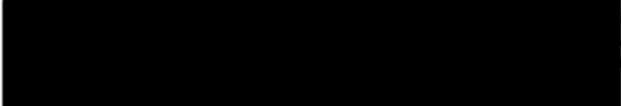
12. IF THE PREMISES ARE LEASED, GIVE NAME AND ADDRESS OF OWNER AND THE TERM OF THE LEASE: (Specify by site if satellites are involved)

Landlord: Dr. Mack Robbyn et 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



aw. state ID Four Women Health Services, LLC  
26-0193943

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 true and correct to the best of my knowledge and belief.

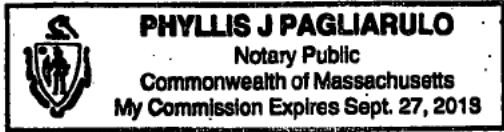
Signature of Applicant (Individual or Person authorized to act in behalf of the Individual Applicant) or Corporate Officer, *Services, LLC*  
Name [REDACTED]

By: [REDACTED]

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

My commission expires on Sept. 27, 2013.

*Phyllis J. Pagliarulo* (Seal)  
Notary Public



©

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

**APPLICATION FOR CLINIC LICENSE RENEWAL**

Date: 4/7/11

*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 <sup>(if same, write same)</sup> Attleboro MA 02703  
Street City or Town Zip Code

4. TELEPHONE: 508 222 7555 FAX: 508 226 2218

5. LICENSE TYPE:  
 RENEWAL LICENSE: 44H2 Date current license expires June 14, 2011

6. SERVICES (check all that apply)

- |  |  |   |
|--|--|---|
| Medical <input checked="" type="checkbox"/>  | Substance Abuse <input type="checkbox"/>         | Dental <input type="checkbox"/>           |
| Surgical <input checked="" type="checkbox"/> | Physical Rehabilitation <input type="checkbox"/> | Mental Health <input type="checkbox"/>    |
| Birth Center <input type="checkbox"/>        | Mobile Medical <input type="checkbox"/>          | Transfusion <input type="checkbox"/>      |
| Pharmacy <input type="checkbox"/>            | Radiology (MRI) <input type="checkbox"/>         | Limited Services <input type="checkbox"/> |

APR 17 2011

7. NAME OF CLINIC ADMINISTRATOR: 

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.

1851500979 260193670  
Federal Identification Number

Note: Your Federal Identification 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 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

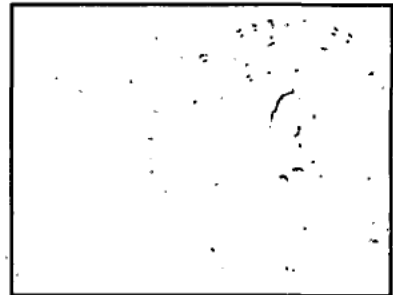
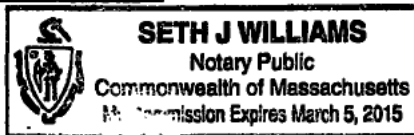
By: \_\_\_\_\_  
Corporate Officer (if applicable)

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

My commission expires on March 5th 20 15.

[Signature]  
Notary Public

(Seal)



\*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]@ppim.org

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

6. SERVICES (check all that apply)

Medical  Substance Abuse \_\_\_\_\_ Dental APR 23 2019

Surgical  Physical Rehabilitation \_\_\_\_\_ Mental Health \_\_\_\_\_  
MA Dept. of Public Health  
99 Chauncy Street  
Boston, MA 02111

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  
Street: 91 Main St. Suite #/Floor: Ste. 103 City/Zip Code: Marlborough, 01752  
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
<b>Open</b>	7:30am	7:30am	7:30am	7:30am	7:30am	7:30am	--
<b>Close</b>	7:00pm	7:00pm	7:00pm	7:00pm	7:00pm	3:00pm	--

Central MA Health Center

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

Western MA Health Center

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

Fitchburg Health Center

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

Marlborough Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
<b>Open</b>	--	--	10:00am	--	10:00am	8:00am	--
<b>Close</b>	--	--	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 of 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 Signature]

\_\_\_\_\_, 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] \_\_\_\_\_  
Signature \_\_\_\_\_ Person authorized act in behalf of \_\_\_\_\_ Corporate Name

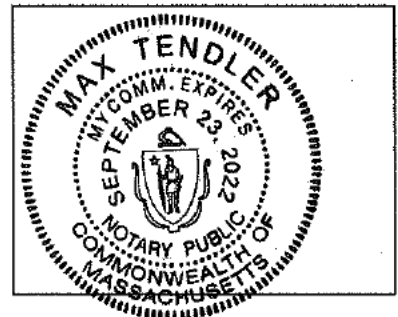
By: \_\_\_\_\_  
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 22<sup>nd</sup> day of April 20 19

My commission expires on 23<sup>rd</sup> day of September 20 22

Max Tendler  
Notary Public

(Seal)



\*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 <sup>(if same, write same)</sup> 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  Substance Abuse \_\_\_\_\_ Dental \_\_\_\_\_  
Surgical  Physical Rehabilitation \_\_\_\_\_ Mental Health \_\_\_\_\_  
Birth Center \_\_\_\_\_ Mobile Medical \_\_\_\_\_ Transfusion \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Lithotripsy \_\_\_\_\_ Limited Services \_\_\_\_\_

7. NAME OF CLINIC ADMINISTRATOR: [REDACTED]

RECEIVED

JUN 22 2017

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

JUN 22 2017  
Rev. 03/25/13

RECEIVED

Planned Parenthood League  
Clinic Name 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

Planned Parenthood League of  
Clinic Name 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)

Planned Parenthood League of  
Clinic Name 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.

04-2098497  
Federal Identification Number

Note: Your Federal Identification 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 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.\*

\_\_\_\_\_  
Signature in behalf of \_\_\_\_\_  
Authorized act Name

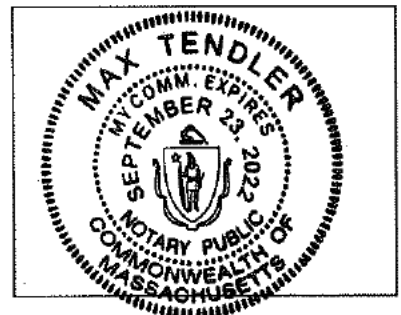
By: \_\_\_\_\_  
Corporate Officer (if applicable)

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)




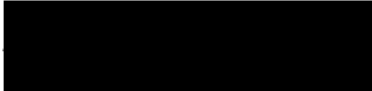
\*Note: All information contained in this application must be kept current.

**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:  @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: 

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, 1<sup>st</sup> 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 1<sup>st</sup> 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 of 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.\*

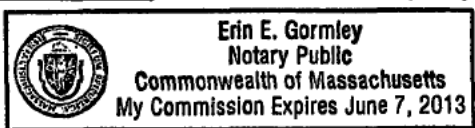
[Redacted Signature]  
Signature of Applicant (Individual or Person authorized act in behalf of the Individual Applicant) or Corporate Name

By: \_\_\_\_\_  
Corporate Officer (if applicable)

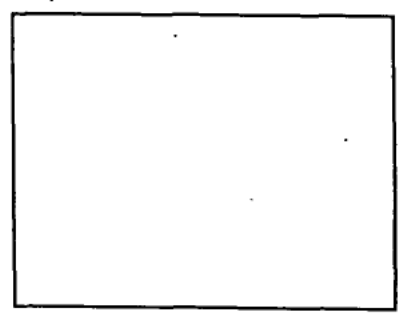
Subscribed and sworn to before me on this 30<sup>th</sup> day of April 20 13

My commission expires on June 7 20 13

[Handwritten Signature]  
Notary Public



(Seal)



\*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, 2<sup>nd</sup> 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 <sup>(if same, write same)</sup> 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  Substance Abuse \_\_\_\_\_ Dental \_\_\_\_\_  
Surgical  Physical Rehabilitation \_\_\_\_\_ Mental Health \_\_\_\_\_  
Birth Center \_\_\_\_\_ Mobile Medical \_\_\_\_\_ Transfusion \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Radiology (MRI) \_\_\_\_\_ Limited Services \_\_\_\_\_

7. NAME OF CLINIC ADMINISTRATOR: 

Clinic Name 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 Worcester/01609  
Street: Suite #/Floor City/Zip Code

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

Services offered: \_\_\_\_\_

Department of Public Safety Certificate Issued: 11/2/2009 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 Fire Certificate Issued: 9/29/2010

Substance Abuse Certificate Issued: N/A

X3. 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: 5/26/13 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 Marlborough/01752  
Street: Suite #/Floor City/Zip Code

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

Services offered: \_\_\_\_\_

Department of Public Safety Certificate Issued: 5/10/2010<sup>2012</sup> Fire Certificate Issued: 5/10/2010

Substance Abuse Certificate Issued: N/A

2. Name of Clinic: Planned Parenthood League of MA

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

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

Services offered: \_\_\_\_\_

Department of Public Safety Certificate Issued: 6/3/10<sup>2012</sup> Fire Certificate Issued: 6/3/10

Substance Abuse Certificate Issued: N/A

3. Name of Clinic: Planned Parenthood League of MA

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

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

Services offered: \_\_\_\_\_

Department of Public Safety Certificate Issued: 7/20/10<sup>2012</sup> 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 of 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  
in behalf

Authorized act  
Name

By: \_\_\_\_\_  
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 28th day of April 20 11

My commission expires on NOV 3 20 12

[Signature]  
Notary Public

(Seal).



\*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, 2<sup>nd</sup> 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 (if same, write same) Commonwealth Ave Boston MA 02215  
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 <sup>4-</sup>

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: 

Clinic Name Planned Parenthood

Application Date 6/1/09

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

1. 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  
Services offered: Medical / Surgical  
Department of Public Safety Certificate Issued: 2/20/2010 Fire Certificate Issued: 9/6 SA 730/4/21/09  
Substance Abuse Certificate Issued: NA

2. 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  
FR 7:45-4p  
SAT 7:45-1p  
Services offered: Medical / Surgical  
Department of Public Safety Certificate Issued: 5/26/08 Fire Certificate Issued: 8/18/08  
Substance Abuse Certificate Issued: NA

3. 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 - 7:15 p  
Wed 7:30 - 4p (2nd/4  
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: NA

(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 of 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)

By: [REDACTED]

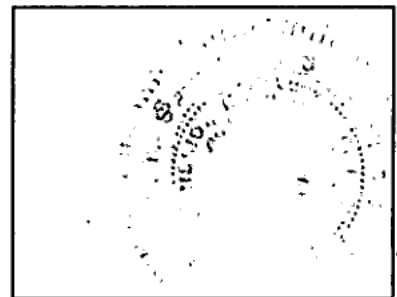
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 1 day of June 2009

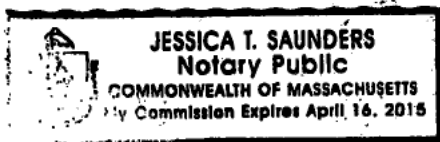
My commission expires on April 16 2015

Jessica Saunders  
Notary Public

(Seal)



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



**COMMONWEALTH OF MASSACHUSETTS**

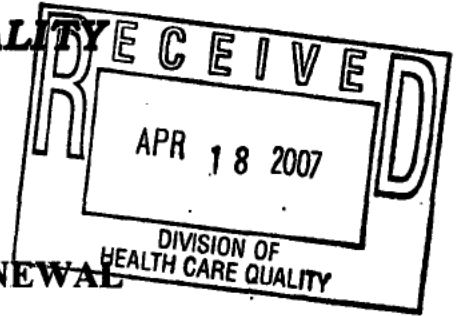
**Department of Public Health**

**DIVISION OF HEALTH CARE QUALITY**

**99 Chauncy Street**

**BOSTON, MA 02111-1212**

**(617) 753-8000**



**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  
(if same, write same) of Greater Boston
- 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 # 5114*

- 6. SERVICES (check all that apply)
 

Medical <input checked="" type="checkbox"/>	Alcoholism _____	Dental _____
Surgical <input checked="" type="checkbox"/>	Physical Rehabilitation _____	Mental Health _____
Birth Center _____	Mobile Medical _____	Transfusion _____
Pharmacy _____	MRI Radiology _____	

7. NAME OF CLINIC ADMINISTRATOR 

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:

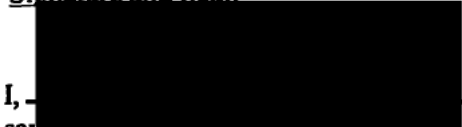
- Less than 5,000 \_\_\_\_\_
- 5,000 - 25,000 \_\_\_\_\_
- 25,000 - 100,000 ✓
- 100,000 - \_\_\_\_\_

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 of 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.

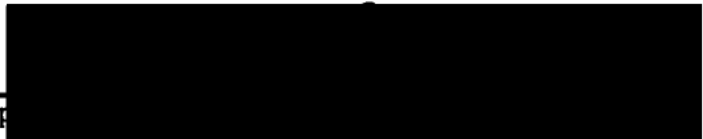
11. Signature and Seal:



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.\*

Planned Parenthood League of MA

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



By: \_\_\_\_\_  
Corp

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

My commission expires on June 7 19 2007.

[Signature] (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

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

2. NAME OF CLINIC: Same

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

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

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

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

6. SERVICES (check all that apply)
- |  |  |   |
|--|--|---|
| Medical <input checked="" type="checkbox"/>  | Substance Abuse <input type="checkbox"/>         | Dental <input type="checkbox"/>           |
| Surgical <input checked="" type="checkbox"/> | Physical Rehabilitation <input type="checkbox"/> | Mental Health <input type="checkbox"/>    |
| Birth Center <input type="checkbox"/>        | Mobile Medical <input type="checkbox"/>          | Transfusion <input type="checkbox"/>      |
| Pharmacy <input type="checkbox"/>            | Lithotripsy <input type="checkbox"/>             | Limited Services <input type="checkbox"/> |

7. NAME OF CLINIC ADMINISTRATOR: 

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 of 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

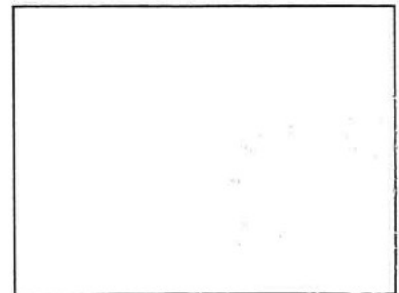
By: \_\_\_\_\_  
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 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**

RECEIVED  
JAN 05 2017  
MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH  
99 Chauncy Street, Boston, MA 02111

**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 <input checked="" type="checkbox"/>  | Substance Abuse _____         | Dental _____           |
| Surgical <input checked="" type="checkbox"/> | 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 of 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

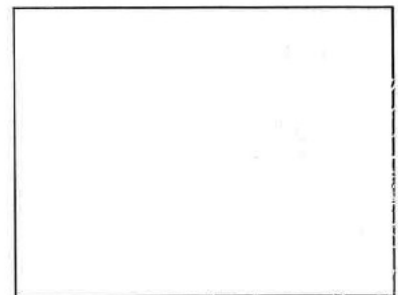
By: \_\_\_\_\_  
Corporate Officer (if applicable)

Subscribed and sworn to before me on this 27 day of December 2016


My commission expires on January 19 2018

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