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

	2	Date:	5/20/19	
In accordance with the "applies for a license to es of the General Laws, Cha	tablish and/or maintain	a clinic at the p	105 CMR 140", the undersigned hereby remises set forth below under provision	v
I. NAME OF LICENS	SEE: Four N	lomen He	ealth Services	
2. NAME OF CLINIC	:Same	*		
3. ADDRESS: 150 Str	D Emory Street	ne, write same) AHLe City or Town	horo 02703 n Zip Code	
4. TELEPHONE: 50	18.222.7555	EMAIL:	FWHS 7555 C. gmail.co	m
5. LICENSE NUMBE	R: 44 H1	Date current	license expires: 6/14/19	
6. SERVICES (check	all that apply)			
Medical	Substance Abuse _		Dental	
Surgical	— Physical Rehabilita	ation —	Mental Health ———	
Birth Center —	— Mobile Medical _		Transfusion	
Pharmacy	_ Limited Services			
7. NAME OF CLIN	IC ADMINISTRATOR	ā _		

N/N

Clinic Name -	
Application Date	

Name of Clinic:			
Street:	Suite #/Floor		City/Zip Code
Telephone Number:	_ Days and Hours	of Operation:	
Services offered:			
Department of Public Safety Certificate Issu	ued:	_ Fire Certificat	e Issued:
Substance Abuse Certificate Issued:			
Name of Clinic:	***************************************	WALSON T.	and the state of t
Street:	Suite #/Floor		City/Zip Code
Telephone Number:	_ Days and Hours	s of Operation:	· · · · · · · · · · · · · · · · · · ·
Services offered:	Lovernage	Mark Mark Mark Mark Mark Mark Mark Mark	
Department of Public Safety Certificate Iss	ued:	_ Fire Certificat	e Issued:
Substance Abuse Certificate Issued:			
Name of Clinic:		And the second second	
Street:	Suite #/Floor		City/Zip Code
Telephone Number:	_ Days and Hour	s of Operation:	
Services offered:			
			e Issued:

(Attach addendum for additional sites, if applicable)

	Application Date 5/29/19
	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.
Ŧ	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:
	say that the statements contained in this license applicationsy knowledge.*
	Signature of Applicant (mulvidual of Ferson authorized actin behalf of the Individual Applicant) or Corporate Name
	By: Corporate Officer (if applicable)
Subs	scribed and sworn to before me on this 23 day of May 20 19
Му	commission expires on $8/13/2021$ 20 21.
	Mi Role (Seal)
*No	te: All information contained in this application must be kept current. AFIA-BARZAN ROSTAMI Notary Public, Commonwealth of Messachuselts My Commission Expires August 13, 2021

Clinic Name Four Women Health Services

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 02111-12 (617) 753-8000

APPLICATION FOR CLINIC LICENSE RENEW

app	ccordance with the "Regu lies for a license to establi he General Laws, Chapter	ish and/or maintain a c	clinic at the pre	05 CMR 140", th mises set forth b	e undersigned hereb elow under provision	y 1S
1.	NAME OF LICENSEE:	Four Women	Health &	blivies		
2.	NAME OF CLINIC: —	Same			· · · · · · · · · · · · · · · · · · ·	
3.	ADDRESS: 150 E Street	mory St. (if same,	write same) Attle City or Town	Ubero	<i>02703</i> Zip Code	
4.	TELEPHONE: 508	-222-7555	EMAIL:	injojourus	omen@gmail.c	om
5.	LICENSE NUMBER:	44HL	Date current li	cense expires: _	06/14/2017	
6.	SERVICES (check all the	nat apply)				
	Medical	Substance Abuse		Dental		
	Surgical	Physical Rehabilitation	on	Mental Health.		
	Birth Center ———	Mobile Medical		Transfusion _		
	Pharmacy	Lithotripsy –		Limited Service	es	
7.	NAME OF CLINIC	ADMINISTRATOR:				

Clinic Name <u>Four Women Heat</u>th Sewiss

Application Date <u>04/20/7017</u>

Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of C	Operation:
Services offered:		
Department of Public Safety Certific	cate Issued: Fi	ire Certificate Issued:
Substance Abuse Certificate Issued	;	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of G	Operation:
Services offered:		
Department of Public Safety Certif	icate Issued: F	ire Certificate Issued:
Substance Abuse Certificate Issued	:	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Cod
Telephone Number:	Days and Hours of	Operation:
Services offered:		

(Attach addendum for additional sites, if applicable)

Clinic Name Four Women Heatth Services
Application Date04 20 2017

		11	, ,		
9.	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 know returns and paid all state taxes required under law. 	ledge and be	lief, have filed all	state tax	
	200193670 Federal Identification Number				
	Note: Your Federal Identification number will be furnished to determine whether you have met tax filing or tax payment obliging or tax payment obligations. Licensees who fail to correctionse suspension or revocation. This request is made under	igations. Lic ct their non-f	ensee who fail to iling or delinquen	correct their nor cy <u>will be subje</u>	n-
11.	11. Signature and Seal:				
	I,, bei say that the statements contained in this license applications who will be a say that the statements contained in this license applications are say that the statements contained in this license applications.	ng first duly	sworn on eath dep	pose and	
			nt (Individual or Pe dual Applicant) of		
	By: Corp	orate Officer	(if applicable)		_
Sub	Subscribed and sworn to before me on this 20 day of _	April	20_/7	·	
Му	My commission expires on April 20		20 <u>23</u>	*	
	Notary Public	(Seal)			
2	Avoiding Public			JACOB B. BOYER Notary Public Massachusetts	
*N	*Note: All information contained in this application must be kept	current.	Commi	ssion Expires Apr 20, 2	023

Rev. 03/25/13

COMMONWEALTH OF MASSACHUSETTS

RECEIVE 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

4/4/12

	Date:
ąр	accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby plies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 131, Section 51 and 56.
1.	NAME OF LICENSEE: Four Women Health Services
2.	
3.	ADDRESS: 150 Emory Street Atteboro MA 02703 Street City or Town Zip Code
	TELEPHONE: 508: 222: 7555 EMAIL:
5.	LICENSE NUMBER: 44+11 Date current license expires: 41+13
5.	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:

Rev. 03/25/13

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

APPLICATION FOR CLINIC LICENSE RENEWAL

	Date: 4/4/13
apj	accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby plies for a license to establish and/or maintain a clinic at the premises set forth below under provisions 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 Street Attleboro MA 02703 Street City or Town Zip Code
4.	TELEPHONE: 508. 222. 7555 EMAIL:
5.	LICENSE NUMBER: 44H1 Date current license expires: 414 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:

NAME AND ADDRESS OF A	ALL SATELLITE LOCATIONS	MAINTAINED UNDER LICEN		
Name of Clinic:				
Street:	Suite #/Floor	City/Zip Code		
Telephone Number:	Days and Hours of	f Operation:		
Services offered:				
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:		
Substance Abuse Certificate	Issued:			
Name of Clinic:	·			
Street:	Suite #/Floor	City/Zip Code		
Telephone Number:	Days and Hours of	f Operation:		
Services offered:		·		
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:		
Substance Abuse Certificate	Issued:			
Name of Clinic:				
Street:	Suite #/Floor	City/Zip Code		
Telephone Number:	Days and Hours of	f Operation:		
Services offered:				
Department of Public Safety	Certificate Issued:	Fire Certificate Issued:		

Clinic Name

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3

	Clinic Name Four Women Heath
	Clinic Name Four Women Heath Service. 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:
	, being first duly sworn on oath depose and say that the statements contained in this needs 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)
Sub	oscribed and sworn to before me on this day of April 20 13 -
Му	commission expires on \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
	MOta I. Quiet (Scal)
Not	tary Public KRISTA LYN RIVET

*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	: —				
2.	NAME OF CLINIC:	FOUR WOMEN	U HEALTH	SERVI	CES	
3.	ADDRESS: 150 Street	EMORY ST.	write same) ATTLEBC City or Town	DRO, MA	<u>02703</u> Zip Code	
4.	TELEPHONE: (508))222-7555	. FAX:	508)226	-2218	
5.	LICENSE TYPE: RENEWAL LICENS	E: X	Date current lic	ense expires <u>6</u>	<u> 14 07</u> ,	
	Pharmacy	Substance Abuse Physical Rehabilitation Mobile Medical Radiology (MRI) —	on 1	Dental (1) Mental Health — Transfusion —	2009 HY -5 PH 9: 39	
7.	NAME OF CLINIC A	ADMINISTRATOR:				

Clinic Name TOUR WOHEN HEATH SERVICES Application Date 4.15.09

	AINTAINED UNDER LICEN	
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of C	Operation:
Services offered:		· · · · · · · · · · · · · · · · · · ·
Department of Public Safety Co	ertificate Issued: Fi	re Certificate Issued:
Substance Abuse Certificate Iss	sued:	
Name of Clinic:		· · ·
Street:	Suite #/Floor	City/Zip Cod
Telephone Number:	Days and Hours of C	Operation:
Services offered:		
Department of Public Safety Co	ertificate Issued: Fi	re Certificate Issued:
Substance Abuse Certificate Iss	sued:	
Name of Clinic:		<u> </u>
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of C	Operation:
Services offered:	······································	
Department of Public Safety Co	ertificate Issued: Fi	re Certificate Issued:
Substance Abuse Certificate Iss	sued:	

(Attach addendum for additional sites, if applicable)

Clinic Name Tour	WOMEN HEALTH SERVICES
Application Date	4.15.09

•	Application Date
9. Number of patients per year: Less than 5,000 5,000 - 25,000 25,000 - 100,000 100,000 -	
 I certify under the penalties of perjury that I, to n returns and paid all state taxes required under law 	•
26 019 39 43 Social Security Number (Voluntary) or Federal Identification Number	
whether you have met tax filing or tax payment o	shed to the Massachusetts Department or Revenue to determine bligations. Licensee who fail to correct their non-filing or tax ct their non-filing or delinquency will be subject to license nder the authority of Mass. G. L. c.62C s.49A.
11. Signature and Seal:	•
say that the statements contained in this license ap my knowledge.*	, being first duly sworn on oath depose and
	in behalf of the Individual Applicant) or Corporate Name
	By Corporate Officer (if applicable)
Subscribed and sworn to before me on this 30H	v day of April 2009.
My commission expires on Aug. 3	2012.
kiindal	(Seal)
Notary Public 4-30-09.	WOAN JING

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

t Women
1.23.07
NDER LICENSE
City/Zip Code
City/Zip Cod

•
City/Zip Code
•

	•	Clinic Name Fo	ur Women
		Application Date —	2.23.07
9. Number of	of patients per year:		
	25,000		
	under the penalties of perjury that I, to nd paid all state taxes required under	o my best knowledge and belief, have law.	filed all state tax
	curity Number (Voluntary) Identification Number		
determine filing or to	e whether you have met tax filing or t ax payment obligations. Licensees w	mished to the Massachusetts Department ax payment obligations. Licensee who have fail to correct their non-filing or detest is made under the authority of Massachusetts.	o fail to correct their non- linquency will be subject
11. Signature		, being first duly sworn on o	Dath depose and
my knowle	edge.*		
efere mc	rnty Messachusetts the understance of the state of the st	Signature of Applicant (Individual A Name By: Corporate Officer (if applications)	pplicant) or Corporate
Subscribed and	d swom to before me or: this	3rd day of February 19 20	07
My commission Deboto Notary Public	un O Dong (S	Seal) Deborah J. Dorn Notary Public Commonwealth of Mas My Commission Expecember 29, 2	sachusetts xpires

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

DPHCQ 136 Rev. 10/05/05

COMMONWEALTH OF MASSACHUSETTS ALTH CARE QUALITY Department of Public Health 2007 FE 26 AM 8:51 DIVISION OF HEALTH CARE QUALITY 99 Chauncy Street BOSTON, MA 02111-1212 (617) 753-8000 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 Emony Street, attleboro, WA 02703 Street City or Town Zip Code	
4. TELEPHONE 508.222.1555	
5. LICENSE TYPE: (A) RENEWAL LICENSE Date current license expires	
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

ASSALTH CARE QUALITY
2307 JE 14 ATT 9: 11

APPLICATION FOR CLINIC LICENSE

	DATE: 6 107	RECEIVED
a lice	coordance with the "Regulations for the Licensure of Clinics, ense to establish and/or maintain a clinic at the premises set oter 111, Sections 51 and 56.	105 CMR 140", the undersigned hereby applies for
-		Health Services LLC
ι.	NAME OF APPLICANT	
2.	NAME OF CLINIC FOUR WOMEN (if same, wri	
3.	ADDRESS 150 EMOTY ST	Attleboro, MA 02703 (City/Town) (Zip Code)
4.	TELEPHONE 508 222 7585	
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 LOCATION (use separate sheet if necess	
	•	

8. NAME OF CLINIC ADMINIST

Clinic Name	Four	L	bмe	4	Health	Serv	ices	LLC
Application Date		6.	1	0	7			

9.	PLEASE CHECK	CATEGORY WHICH BES	ST DESCRIBES APPLICANT:
----	--------------	---------------------------	-------------------------

a)	Governmental Ownership			
b)	Sole Proprietorship (Individual)	•	٠	
c)	Partnership (if limited, please check)			
d)	charitable (G.L.C. 180) Corporation			
e)	Proprietary (G.L.C. 156A or 156B)			
n	Other (specify exact nature)			

10. IDENTITY OF APPLICANT - Specify below:

- 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.
- 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.



		•	Clinic Name Four	- Women Healt	h services we
	,		Application Date	6/1/07	·.
11.	RESP	ONSIBILITY AND SUITABII	LITY	•	
a)	Has the	e applicant* owned stock or a pa administrator of; acted as a gu that has been the subject of a	parantor or co-signed for the bankruptcy petition?	nore of; served a member, di debts of; or loaned money to	rector, officer or , any health care facility
		Yes	No		
	,	If yes, describe:			
			·		
·				· .	•
	b)	Has applicant*, or any of its c charged with any criminal off	ense?	c administrator ever been inc	licted or formally
		Yes	No		
		If yes, was the applicant or cl or admit facts in a judicial pro			
		Yes	No	•	
•		If the answer to the second que which they were brought, doc	nestion is yes, explain, includ		, the jurisdiction(s) in
				•	. ·
				·	
	c)	Has the applicant* owned sto officer or administrator of any or any other jurisdiction to lin Medicare certification, or Me	y health care facility which h nit, suspend, revoke, refuse o	as been the subject of procee	edings in Massachusetts
•		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.

12.	LEASE: (Specify by site if satellite	GIVE NAME AND ADDRESS OF OW es are involved	NER AND THE TERM OF THE
	Landlord: br.	Mark Robbin at	RJ Realty, LLC 150 Emory St Attleboro, MA 02703
		lease extends	to 2011
			•
13.	NUMBER OF VISITS PER YEAR:		
	Less than 5,000		· .
	5,000 - 25,000		
	25,000 - 100,000	•	
	100.000		
	100,000 +		

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.

SIGNATURE and SEAL	· ·
	being first duly sworn on oath depose and say that the
statements contained in this license application are	transfer to the heart and death
•	Signature of Applicant (Individual or Person authorized
	to act in behalf of the Individual Applicant) or Corporate
	By:
Subscribed and swom to before me on this	_day of <u>Juno</u> , 2007.
My commission expires on Sept. 27	. , 2013
() 1 0 0 0 1	
Notaty Public / Od / Notaty Public	(Seal)

15.

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
арј	accordance with the "Regulations for the Licensure of Clinic, 105 CMR 140", the undersigned hereby plies for a license to establish and/or maintain a clinic at the premises set forth below under provisions the General Laws, Chapter 111, Section 51 and 56.
1.	NAME OF LICENSEE: Four Women Health Services
2.	NAME OF CLINIC:
3.	ADDRESS: 150 Emory St Atteboro MA 02703 Street City or Town Zip Code
4.	TELEPHONE: 508 2227555 FAX: 508 226 2218
5.	RENEWAL LICENSE: Date current license expires June 14, 2011
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	Four Women		
Application Date	417/11		

Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Ope	eration:
Services offered:		
Department of Public Safety Cer	rtificate Issued: Fire	Certificate Issued:
Substance Abuse Certificate Issu	ued:	
N. COL		
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Op	eration:
Services offered:		
Department of Public Safety Ce	ertificate Issued: Fire	Certificate Issued:
Substance Abuse Certificate Iss	ued:	
Name of Chining		
Name of Child: ————	·	
		· Other Ware Control
Street:	Suite #/Floor	City/Zip Code
Street:	Suite #/Floor Days and Hours of Op	· ·
Street:	Days and Hours of Op	City/Zip Code

		Clinic Name	<u>Four Women</u>
	•	Application	Date 4/7/11
9.	Number of patients per year: Less than 5,000		
10.	I certify under the penalties of perjury that I, to returns and paid all state taxes required under		elief, have filed all state tax
j	1851500979 26019 Federal Identification Number	3670	•.
	Note: Your Federal Identification number wil determine whether you have met tax filing or tax filing or tax payment obligations. Licensees whether suspension or revocation. This request	ax payment obligations. Li	censee who fail to correct their non-filing or delinquency will be subject to
11.	Signature and Seal:	•	m · ·
	I, say that the statements contained in this ricense my knowledge.*	application are true, comp	y sworn on oath depose and lete and correct to the best of the lete and correct to the let
r		By: Corporate Office	r (if applicable)
Sub	scribed and sworn to before me on this 6	day of April	_ 20 <u> ll</u>
Му	commission expires on March 5 th		_20 <u>15</u>
\	Common	(Seal) TH J WILLIAMS Notary Public wealth of Massachusetts ission Expires March 5, 2015 on 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: \(\frac{4}{22/2019} \)

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 Par	enthood 1	eague of	MassachuseHs	, Inc.
2.	NAME OF CLINIC: L	lanned Paren	thood leav	gve of Ma	srachisetts	
3.	ADDRESS: 1055 (OMMONWEALLY	write same) No. Bosh City or Town		Zal5 Zip Code	
4.	TELEPHONE: 617	-616-1600	EMAIL:		@ppim.org	
5.	LICENSE NUMBER:	4174	Date current 1	icense expires: _	6-23-19	
6.	SERVICES (check all t	hat apply)		RE	CEIVED	
	Medical	Substance Abuse			APR 2 3 2019	
	Surgical X	Physical Rehabilitati	on ———	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:			,	

Planned Parenthood Clinic Name Legue 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 cente
	470 Pleasant St. Words ter, 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
	3550 Main St. Ste. 201 Springfield, M 01107 Street: Suite #/Floor City/Zip Code
	Telephone Number: 413-732-1620 Days and Hours of Operation: See a Hacked Services offered: Medical, Swajcal
	Department of Public Safety Certificate Issued: Fire Certificate Issued: Substance Abuse Certificate Issued:
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 a Huched
	Services offered: Medical
	Department of Public Safety Certificate Issued: Fire Certificate Issued:
	Substance Abuse Certificate Issued: N/A

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Planned Parenthood Clinic Name League of Massachusetts Application Date 4/22/2019

8.	NAME AND ADDRESS OF A	LL SATELLITE LOCATIO	NS MAINTAINED UNDER LIC	ENSEE:
1.	Name of Clinic: Planned	Parenthood league	of Mascaenusetts - N	larlboro
	91 Main St. Street:	Ste. 103 Suite #/Floor	Marlborough, O City/Zip Cod	1752
	•		rs of Operation: Sel attac	
	Services offered: Medi	cal		_
	Department of Public Safety (Certificate Issued:	Fire Certificate Issued:	· · · · · · · · · · · · · · · · · · ·
	Substance Abuse Certificate I	ssued: V/A		
2.	Name of Clinic:			·
	Street:	Suite #/Floor	City/Zip C	ode
	Telephone Number:	Days and Hou	ers of Operation:	
	Services offered:			
	Department of Public Safety	Certificate Issued:	Fire Certificate Issued:	/
	Substance Abuse Certificate I	ssued;		
3.	Name of Clinic:			· · · · · · · · · · · · · · · · · · ·
	Street;	Suite #/Floor	City/Zip (Code
	Telephone Number:	Days and Hot	urs of Operation:	
	Services offered:		**************************************	
	Department of Public Safety	Certificate Issued:	Fire Certificate Issued:	
	Substance Abuse Certificate 1	ssued:	MANAGEMENT	

Rev. 10/31/17

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

	Greater B	oston H	ealth Cente	r					
	Mon	Tues	Wed	Thu	rs	Fri	Sat		Sun
Open	7:30am	7:30am	7:30am	7:30	am	7:30am	7:3	0am	
Close	7:00pm	7:00pm	7:00pm	7:00	pm	7:00pm	3:0	0pm	
	Central M	IA Healt	th Center						
	Mon	Tues	Wed	Thu	rs	Fri	Sat	t	Sun
Open	8:00am	8:00am	8:00am	8:00	am	8:00am	8:0	0am	
Close	7:15pm	3:45pm	7:15pm	7:15	pm	5:00pm	2:0	0pm	
Open Close	Western Mon 8:00am 5:00pm	MA Hea Tues 8:00ai 7:30p		n	Thurs 8:00am 7:30pm	Fri 7:45a 5:00p		Sat 	Sun
	Fitchburg	; Health	Center						
	Mon	Т	ues	Wed	Thur	s	Fri	Sat	Sun
Open	10:00am		0:00am		10:00				
Close	4:00pm	7	:30pm		7:30p	om			
		ugh Hea	ılth Center						
	Mon		Wed	Thurs	Fr		Sat		Sun
Open			10:00am	***		00am	8:00		
Close			7:30pm		4:0	0pm	1:00	pm	

9.	Number of patients per year	•
	Less than 5,000———	_
	5,000 - 25,000	_
	25,000 – 100,000	
	100,000 -	

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax
returns and paid all state taxes required under law.

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:

say mat the statements contained in this needse applimy knowledge.*		sworn on oath depose and ete and correct to the best of
	Signatu in beha	rson authorized ac
	By: Corporate Officer	(if applicable)
Subscribed and sworn to before me on this 22 nd My commission expires on 23 rd day of	day of April	20 19
My commission expires on 23rd day of	September	20 22
Max Tandles Notary Public	(Seal)	TENDO COMPANIE
*Note: All information contained in this application mu	ast be kept current.	MARY PORT OF THE PROPERTY OF T

Rev. 10/31/17

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

ap	accordance with the "Reg plies for a license to establ the General Laws, Chapte	lish and/or maintain a c	linic at the pre				
1.	NAME OF LICENSEE:	flanned Pare	nthood 1	tague of M	lassach	lusetts, In	₫,
2.	NAME OF CLINIC: $\frac{1}{2}$	'lanned Pare	ntheed L	eague of M	bss2d	nuscets	
3.	ADDRESS: 055 C		rite same) BO City or Town		DQQ\(Zip Code	5_	
4.	TELEPHONE: 617	-616-1600	EMAIL		epplm.	org	
5.	LICENSE NUMBER:	1174	Date current li	cense expires: 6	-23-15	}	
6.	SERVICES (check all t	hat apply)					
	Medical	Substance Abuse		Dental			
	Surgical	Physical Rehabilitation	n	Mental Health			
	Birth Center —	Mobile Medical	= 3	Transfusion	27		
	Pharmacy	Lithotripsy —		Limited Services	MA Dept o		
7	11130 NAME OF CLINIC	ADMINISTRATOR:			if Public uncy S NIA 03	Samuel Comments	

AM Dept. of Public Health

Planned Parenthood league Clinic Name of Mossachusetts, Inc. Application Date 6-22-17

8.	NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE:
1.	Name of Clinic: Planned Panenthood League of Mossochusetts - Central MA con
	Street: Suite #/Floor Workester, Mt 01609
	butter. State mixton
	Telephone Number: 508-854-3300 Days and Hours of Operation: DC Atto Nod
	Services offered: Medical, Sulfical
	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
	3550 Main H 54201 Springfield MA 01107 Street: Suite #/Floor City/Zip Code
	Telephone Number: 413-732-1620 Days and Hours of Operation: See Stanfield
	Services offered: Mcdical, Sulfical
	Department of Public Safety Certificate Issued: Fire Certificate Issued:
	Substance Abuse Certificate Issued: 1
3.	Name of Clinic: Planned Paronthood League of Massachusetts - Fitch burg
	391 Mov St Street: Suite #/Floor Fitchburg MA OLLRO City/Zip Code
	Telephone Number: 508-854-3800 Days and Hours of Operation: See 342-3400
	Services offered: Medical
	Department of Public Safety Certificate Issued: Fire Certificate Issued:
	Substance Abuse Certificate Issued:

Planned Parenthood League
Clinic Name Massachusetts, Inc.
Application Date 6-22-17

3.	NAME AND ADDRESS OF ALL SAT			
1.	Name of Clinic: Planned Paten	thood League c	of Massachuset	ts-Marlhoro
	91 Main St Street:	Suite #/Floor	Mari Donodina M	MA 0175
	Telephone Number: 508-884-3	Days and Hours	'	ellached
	Department of Public Safety Certifica			
	Substance Abuse Certificate Issued: -	N/A	муналина	
2.	Name of Clinic:			
	Street:	Suite #/Floor	C	ity/Zip Code
	Telephone Number:	Days and Hour	rs of Operation:	
	Services offered:	•		
	Department of Public Safety Certifica	ate Issued:	Fire Certificate Issued	i:
	Substance Abuse Certificate Issued:		•	
3.	Name of Clinic:			
	Street:	Suite #/Floor	(City/Zip Code
	Telephone Number:	Days and Hou	rs of Operation:	
	Services offered:		A CONTRACTOR OF THE CONTRACTOR	· · · · · · · · · · · · · · · · · · ·
	Department of Public Safety Certific	ate Issued:	Fire Certificate Issue	d;
	Substance Abuse Certificate Issued:	X		

Greater Boston Health Center

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

Central MA Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	8:00am	8:00am	8:00am	8:00am	8:00am	8:00am	W/ 64
Close	7:15pm	3:45pm	7:15pm	7:15pm	5:00pm	2:00pm	Www.mer

Western MA Health Center

	Mon	Tues	Wed	Thurs	500 00° 1	Sat	Sun
Open	8:00am	8:00am	7:45am	8:00am	7:45am	304-506	e200 ; 150g.
Close	5:00pm	8:00pm	5:00pm	8:00pm	5:00pm	42 Je	.a. 10a

Fitchburg Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	10:00am	10:00am	00-00	10:00am	.004 NW	pa pip	
Close	4:00pm	7:30pm	III. SEE	7:30pm	0549 7029	NUO 9020	Since Stick

Marlborough Health Center

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Open	M XE	Opr èm	10:00am	623. Tills.	10:00am	8:00am	SB-63
Close	XV:SA	40 to	7:30pm	ESC. Intr.	4:00pm	1:00pm	Mayor secul

(Attach addendum	for	additional	sites,	if applicable)
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Planned Clinic Name Mas	forenthood League of SSOchusetts, 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.

OH-2018497 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, say that the statements contained in this license app my knowledge.*	, being first duly sworn on oath depose and application are true, complete and correct to the best of			
	Signatu in beha			_ rized act Name
	By: Corpo	rate Officer	(if applicable)	
Subscribed and sworn to before me on this 22	day of	كاندمع	20_17	
My commission expires on 23 September, 20	೦೨೩		_20	
Max Ceroller Notary Public		(Seal)	TENO	A
*Note: All information contained in this application m	oust be kept o	current.		4410017

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: Apr	12,2013	
ıpı	_	ish and/or maintain a	clinic at the pre	05 CMR 140", the undersign emises set forth below under	,
۱.	NAME OF LICENSEE:	PLANNED PAR	ENTHOSO LE	A GUE OF MASSACHUSE	ITS, INC.
2.		NCES OF GREATER T	BOOTON	MASSACHUSETTS / PRETER	<u>LM H</u> EAUT
	ADDDDDDD	•	write same)		
3.	ADDRESS: 1055 Con Street	Y WON WEBLTH AV	City or Town		
4.	TELEPHONE: 617-	616-1600	EMAIL:	Opplm.org	
5.	LICENSE NUMBER:_	4174	Date current l	icense expires: O6/23/201	<u>3</u>
6.	SERVICES (check all the	nat apply)			
	Medical	Substance Abuse	·	Dental	
	Surgical —	Physical Rehabilitation	on ———	Mental Health	
	Birth Center ———	Mobile Medical		Transfusion	_
	Pharmacy	Radiology (MRI) -		Limited Services	
7.	NAME OF CLINIC	ADMINISTRATOR:			_

Clinic Name League of MA, Inc.

Application Date 04/02/2013

Q	NAME	AND	ADDRESS	OF ALL	SATELLITE L	OCATIONS MA	ANTAINED	INDER	LICENSEE:
o.	TANAMATA	$\boldsymbol{\Delta}$					777 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ナルヘル・ハルル・

	Alma Thanas		1 to 2000 444 644 66
	Street:	Suite#/Floor	City/Zip Code
	Telephone Number: <u>508-854-3300</u>	Days and Hours	of Operation: Please see attached document
	Services Offered: Medical; Surgica	<u></u>	
	Department of Public Safety Certificate Issu	red: 11/15/2011	Fire Certificate Issued: 0(24/2013
	Substance Abuse Certificate Issued: N/A		
2.	Name of Clinic: Planned Pareuthoco	a readine of u	Massachusetts - Western MA Center
	3550 Maio Street Street:	Suite#/Floor	Springfield, MA01107 City/Zip Code
	Telephone Number: 413-732-1620	Days and Hours	of Operation: Please see attached clocument
	Services Offered: Medical; Surgica	<u>. </u>	
	Department of Public Safety Certificate Issu	ned: <u>05 02 2011</u>	Fire Certificate Issued: 09/12/2012
	Substance Abuse Certificate Issued: N/A		
3.	Name of Clinic: Planed Parenthee	d Leaque of M	vassachusetts - Milford
	208 Main Street Commerces Street:	Suite#/Floor	Floor Milford, MA 01757 City/Zip Code
	Telephone Number: 508-854-3300	Days and Hours	of Operation: <u>Please See attached</u> document
	Services Offered: <u>medical</u>		
	Department of Public Safety Certificate Issu	ned: <u>04/24/13</u>	Fire Certificate Issued: 66/03/2010
	Substance Abuse Certificate Issued: N/A		
(A 1	ttach addendum for additional sites, if applicable)		•

Rev. 03/25/13

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

1.	Name of Clinic: Planned Parenthees	d League of M	Passachusetts - Fitchburg
	391 Main Street Street:	Suite#/Floor	Fitchburg, MA 01420 City/Zip Code
	Telephone Number: <u>508-854-3300</u>	Days and Hours of	f Operation: Please see attached document
	Services Offered: Medical		
	Department of Public Safety Certificate Issu	ed: <u>04 25 2013</u>	Fire Certificate Issued: 77/20/2010
	Substance Abuse Certificate Issued: NIA		·
2.	Name of Clinic: Planned Parentheed	League of Ma	essachusetts - Marlborough
	91 Maio Street Su Street:	Suite#/Floor	City/Zip Code
	Telephone Number: <u>509-854-3360</u>	Days and Hours of	f Operation: Please see attached
	Services Offered: Medical		
	Department of Public Safety Certificate Issu	red: <u>04/24/2013</u>	Fire Certificate Issued: OS 10 2010
	Substance Abuse Certificate Issued: NIA		_
3.	Name of Clinic:		
	Street:	Suite#/Floor	City/Zip Code
	Telephone Number:	Days and Hours of	f Operation:
	Services Offered:		
	Department of Public Safety Certificate Issu	ned:	Fire Certificate Issued:
	Substance Abuse Certificate Issued:		-

(Attach addendum for additional sites, if applicable)

Rev. 03/25/13

Clinic Name Planned Parenthons League of	£
Application Date 64/02/13	

9.	Number of Outpatients per year: Less than 5,000 —————————————————————————————————
10.	I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.
	Federal Identification Number
	Note: Your Federal Identification number will be furnished to the Massachusetts Department or Revenue to determine whether you have met tax filing or tax payment obligations. Licensee who fail to correct their non-filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G. L. c.62C s.49A.
11.	Signature and Seal: I,
	By: Corporate Officer (if applicable)
	bscribed and sworn to before me on this 35th day of April 20 13 y commission expires on 20 13
No	Otary 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.

Rev. 03/25/13



COMMONWEALTH OF MASSACHUSETTS HEALTH CARE QUALITY EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES Department of Public Health Department of Public Health

Bureau of Health Care Safety and Quality 99 Chauncy Street, 2nd Floor, Boston, MA 02111-1212 (617) 753-8000

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 Parenthoo	od league of MA
2.	NAME OF CLINIC: -	Planned Parenthou	d league of MA
3.	ADDRESS: 1055 Street		e BOSTON, MA 02215 wn Zip Code
4.	TELEPHONE: 617.	616-1600 FA	x: 617. 616.1665
5.	LICENSE TYPE: RENEWAL LICENS	SE: X4174 Date currer	nt license expires <u>6/23/1</u>
6.	SERVICES (check all t	hat 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 Lagre of MA
	Street: Suite #/Floor Worldster/01609 City/Zip Code
	Telephone Number: 568-854-3300 Days and Hours of Operation:
	Services offered:
	Department of Public Safety Certificate Issued: 1112/2011 Fire Certificate Issued: 222/2011
	Substance Abuse Certificate Issued: NA
2.	Name of Clinic: Planned Paventhad league of Ma
-	3550 Main Street Suite 201 Spring held/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:
X 3.	Name of Clinic: Planned Parenthood lagre of MA - PLAN
٠	260 Flm Street Suite 109, Davis Square Somervile/0210 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 5 Fire Certificate Issued: 5 25 1
	Substance Abuse Certificate Issued: N/A
(A1	tach 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: Mark Street: Suite #/Floor City/Zip Code
	Substitute of the substitute o
	Telephone Number: 508-970-1100 Days and Hours of Operation:
	Services offered:
	Department of Public Safety Certificate Issued: 5/10/2010 Fire Certificate Issued: 5/10/2010
	Substance Abuse Certificate Issued:
2. .	Name of Clinic: Planned Parenthond League of MA
	268 Main Street Miford/01757 Street: Suite #/Floor Clty/Zip Code
	Telephone Number: 508-458-334D Days and Hours of Operation:
	Services offered:
	Department of Public Safety Certificate Issued: 6/3/10 Fire Certificate Issued: 6/3/10
	Substance Abuse Certificate Issued:NA
3.	Name of Clinic: Planned Parenthood league of MA
	39 Main Street Filling/01420 Street: Suite #/Floor Fithbug/01420
	Telephone Number: 976-Slb-0900 Days and Hours of Operation:
•	Services offered:
	Department of Public Safety Certificate Issued: 7/20/10 Fire Certificate Issued: 3/20/10
	Substance Abuse Certificate Issued: N/A
(Atta	ch addendum for additional sites, if applicable)

Clinic Name Planned Reventhed Leave of MA Application Date April 27, 2011

9. Number of patients per year:				
Less than 5,000			• .	
25,000 – 100,000X			•	
100,000 -				
 I certify under the penalties of perjury that returns and paid all state taxes required un 		wledge and belief,	have filed all state tax	
04-2698497 Federal Identification Number				
· · · · · · · · · · · · · · · · · · ·		•		
Note: Your Federal Identification number determine whether you have met tax filing filing or tax payment obligations. License license suspension or revocation. This required	or tax payment ob es who fail to corr	oligations. License ect their non-filing	e who fail to correct the or delinquency will b	heir non- e subject to
11. Signature and Seal:	· .			·. ·
y.		6 1.1		
12			m on oath depose and nd correct to the best o	
my knowledge.*	· ·			
•				<u> </u>
	Signatu			rized act
	in behal			Name
	· .			
. · ·	Ву:			
	Cor	porate Officer (if a	pplicable)	
Subscribed and sworn to before me on this	28 th day of	April 20	11	
My commission expires on Nov	23	20	12	·:
Notary Public L2		(Seal).	REPUBLICATION 3 20 Ptg	Cam
	1.3		* 3 1	*****
*Note: All information contained in this appli	cation must be kep	t current.	Comment of	ARRESPONDED IN THE PARTY OF THE
		.	ACHUSE LIN	·

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

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

apj	accordance with the "Reg plies for a license to estab the General Laws, Chapte	lish and/or maintain a	clinic at the pro		•	
1.	NAME OF LICENSEE	Planned Par	renthood	Lea	que of 1	<u>u</u>
2.	NAME OF CLINIC: -	Planned Para	enthood	Leagu	ve of M	4
3.	ADDRESS: 1055 Street	Commo	m weelfu	Ave	Buston 1	M OZZIS
4.	TELEPHONE: 617					
5.	LICENSE TYPE: RENEWAL LICENS	E:	Date current li	cense exp	oires 6 23	L09.
6.	SERVICES (check all the	hat apply)				
	Medical	Substance Abuse	· · · · · · · · · · · · · · · · · · ·	Dental _		_
	Surgical	Physical Rehabilitation	on	Mental H	lealth	
	Birth Center	Mobile Medical	· ·	Transfus	ion	
	Pharmacy	Radiology (MRI) —				
7.	NAME OF CLINIC	ADMINISTRATOR:			·	

	Clinic Name Planner Pavent Hood
	Application Date 6/1/09
, 8. J	NAME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE:
W.	Name of Clinic: Plannea Parenthood League of MA # 4163
	631 Lincoln St. Worcester, MA 01605 Street: Suite #/Floor City/Zip Code
	M o E
	Telephone Number: 508.854.3300 Days and Hours of Operation: T \$30.4
	Services offered: Medical Sugical Transfer
	Services offered: Medical Sugicel Department of Public Safety Certificate Issued: 220 20 10 Fire Certificate Issued: 421 09
•	Substance Abuse Certificate Issued:
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: Tue 8-8
	Services offered: Medical Surgical FR: 7:45-4P
	Department of Public Safety Certificate Issued: 521 Ph Fire Certificate Issued: 81808
	Substance Abuse Certificate Issued:
13,	Name of Clinic: Planned Paventhood League of MA
	1055 Commonwealth Are Buston MA 02215 Street: Suite #/Floor City/Zip Code
	M, T, Th, F 7:30 · 7:15 p Telephone Number: 617-616-1600 Days and Hours of Operation: Wed 7:30 - 4 P(2nd)

(Attach addendum for additional sites, if applicable)

Substance Abuse Certificate Issued: ________

Department of Public Safety Certificate Issued: 10 30 08

_ Fire Certificate Issued: 306

		Cililic I varing	
		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 me returns and paid all state taxes required under law		elief, have filed all state tax
	O + 2 6 9 8 4 9 7 Social Security Number (Voluntary) or Federal Identification Number		
	Note: Your social security number will be furnis whether you have met tax filing or tax payment of payment obligations. Licensees who fail to corresuspension or revocation. This request is made up	bligations. Licensee who ct their non-filing or deli	o fail to correct their non-filing or tax nquency will be subject to license
11.	Signature and Seal:		
			sworn on oath depose and ete and correct to the best of
	my knowledge.*	Planned Pare	nthood league of 144.
		Signature of Applicar	nt (Individual or Person authorized act
	,	in beha	e
C1		day of JUNE	20.09
	commission expires on . D(1) 10	day of	20 15
	Commission expires on 1917 TV	(Seal)	-20 15
No	taryPublic		3
*N	ote: All information contained in this application n	nust be kept current.	
	JESSICA T. SAUNDERS Notary Public COMMONWEALTH OF MASSACHUSETTS Commission Expires April 16, 2015		AMBBBBB.

Clinic Name Planned Parthaul

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 RENEWA

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 Parentho	ood League of MA	
2. .	NAME OF CLINIC	Planned Parenthood (if same, write same	Preterm Health Service	7
3.	ADDRESS 1055 Street	Common wealth Ave City or To	OWN Zip Code	
4.	TELEPHONE 617	-616-1600		
5.	LICENSE TYPE: (A) RENEWAL LICE	INSE Date curre	ent license expires 6 23 2007	<u> </u>
6.	SERVICES (check all t	hat apply)	•	
	Medical	Alcoholism	Dental	
	Surgical	Physical Rehabilitation ———	- Mental Health -	
	Birth Center	Mobile Medical	Transfusion	
	Pharmacy	MRI Radiology		
	NAME OF CLINIC AD	MINISTRATOR ·		

Rev. 10/05/05

	Clinic Name Planned Parenthous
	Application Date 4907
8. NA	ME AND ADDRESS OF ALL SATELLITE LOCATIONS MAINTAINED UNDER LICENSEE:
SATE	LLITES:
1.	Name of Clinic: Planned Parenthood league of MA.
	631 Lincoln St . Worcester MA 01605 Street: Suite #/Floor City/Zip Code
	<u>.</u>
	Telephone Number (508) 854-3300 Days and Hours of Operation: See at tacked
	Services offered: Medical, Surgical
	DPS Issued 3 2 2009 Fire Issued 1-16-2007
2.	Name of Clinic: Planned Parenthood League of M1
	3550 Main Street #201 Springfield MA 01107 Street: Suite #/Floor City/Zip Code
	Telephone Number: 413 732 1670 Days and Hours of Operation: See attacked
	Services offered: Medical, Surgical
	scrvices official.
	DPS Issued # 17/09 Fire Issued 8 30 2006
3.	Name of Clinic:
	Street: Suite #/Flook City/Zip Code
	Telephone Number: Days and Hours of Operation:
	Services offered:
	DPS Issued: Fire Issued:
	(Attach addendum for additional sites, if applicable)

	Application Date —————
9.	Number of patients per year:
	Less than 5,000
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.
	OHZ698497 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.	I,, being first duly swom 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:
Sut	oscribed and sworn to before me on this 200 day of 49-200 7
Му	commission expires on
Y No	tary Public (Seal)

Clinic Name Planned Pare- thoud

*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	,	
ipp	accordance with the "Regi plies for a license to establ the General Laws, Chapter	ish and/or maintain a r 111, Section 51 and 5	clinic at the pro 56.	emises set forth	i below under provisio	ns
ι.	NAME OF LICENSEE:	Women's Ho	eath Serv	ices, P.C	OCT 1 9 2017	Smerra Smerra
2.	NAME OF CLINIC: -				MA Dept. of Public He 99 Chauncy Street	alth
3.	ADDRESS:	vard Stret (if same,	write same) City or Town		Zip Code	
4.	TELEPHONE: (617)	277-0009	EMAIL:		@ partners.org	ć
5.	LICENSE NUMBER:_	A304	Date current 1	icense expires:	11. 23.17	
6.	SERVICES (check all t	hat apply)				
	Medical	Substance Abuse		Dental		
	Surgical	Physical Rehabilitation	on	Mental Healt	h	
	Birth Center ———	Mobile Medical		Transfusion		
	Pharmacy	Lithotripsy —		Limited Serv	ices	
7.	NAME OF CLINIC	ADMINISTRATOR:				

Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	tion:
Services offered:		
Department of Public Safety Cer	tificate Issued: Fire Ce	ertificate Issued:
Substance Abuse Certificate Issu	ed:	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	ation:
Services offered:		
Department of Public Safety Certificate Issued:		ertificate Issued:
Substance Abuse Certificate Issu	ned:	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Opera	ation:

(Attach addendum for additional sites, if applicable)

	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 returns and paid all state taxes required under law	
determine whether you have met tax filing or tax p filing or tax payment obligations. Licensees who	furnished to the Massachusetts Department or Revenue to bayment obligations. Licensee who fail to correct their non-fail to correct their non-fail to correct their non-filing or delinquency will be subject to made under the authority of Mass. G. L. c.62C s.49A.
Il say that the statements contained in this license approximy knowledge.*	, being first duly sworn on oath depose and plication are true, complete and correct to the best of Signature of Applicant (Individual of Person authorized actin behalf of the Individual Applicant) or Corporate Name
Subscribed and sworn to before me on this 16 My commission expires on Jamuary 19 Notary Public	By: Corporate Officer (if applicable) day of OCADOC 20 ZOLT. 20 6 . (Seal)
*Note: All information contained in this application in KRISTEN F Notary Commonwealth of My Commiss January	Public f Massachusetts ion Expires

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

COMMONWEALTH OF MASSACHUSETTS

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

Department of Public Health

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

APPLICATION FOR CLINIC LICENSE RENEW

			Date: 12.	27.16	
арр	ccordance with the "Regu lies for a license to establi he General Laws, Chapter	ish and/or maintain a	clinic at the pre	5 CMR 140", the mises set forth be	undersigned hereby low under provisions
1.	NAME OF LICENSEE:	Women's Ho	ealth Serv	ices, P.C	
2.	NAME OF CLINIC: —				
3.	ADDRESS:	rvard Street	write same) City or Town	, MA	02446 Zip Code
4.	TELEPHONE: (617)2				partners, org
5.	LICENSE NUMBER:_	A304	Date current li	cense expires:	
6.	SERVICES (check all the	nat apply)			
	Medical	Substance Abuse		Dental	· ·
	Surgical	Physical Rehabilitati	on	Mental Health _	
	Birth Center ———	Mobile Medical		Transfusion	
	Pharmacy	Lithotripsy -		Limited Services	S
7.	NAME OF CLINIC	ADMINISTRATOR:	_		

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

Application Date 12. 27.16

Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Ope	ration:
Services offered:		
Department of Public Safety Cer	tificate Issued: Fire	Certificate Issued:
Substance Abuse Certificate Issu	ned:	
Name of Clinic:		
Street:	Suite #/Floor	City/Zip Code
Telephone Number:	Days and Hours of Ope	eration:
1		
•		
Services offered:	rtificate Issued: Fire	
Services offered: Department of Public Safety Cer		
Services offered: Department of Public Safety Cer Substance Abuse Certificate Issu	rtificate Issued: Fire	Certificate Issued:
Services offered: Department of Public Safety Cer Substance Abuse Certificate Issu	rtificate Issued: Fire ued:	Certificate Issued:
Services offered: Department of Public Safety Cer Substance Abuse Certificate Issu Name of Clinic: Street:	rtificate Issued: Fire ued:	Certificate Issued: City/Zip Code
Services offered: Department of Public Safety Cer Substance Abuse Certificate Issu Name of Clinic: Street: Telephone Number:	rtificate Issued: Fire ued: Suite #/Floor	City/Zip Code

(Attach addendum for additional sites	if ap	plicable'
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	and the same of	Clinic Name	Women's Health	Servius, P	1.6
		Application I	Date 12.27.11)	_
9. Number of Outpatients v Less than 5,000 —————————————————————————————————	_				
 I certify under the penalt returns and paid all state 	ies of perjury that I, to my taxes required under law.	best knowledge and be	lief, have filed all st	ate tax	
14. 3151452 Federal Identification Nur	nber				
determine whether you ha filing or tax payment obli	atification number will be ave met tax filing or tax paragrations. Licensees who from the control of the contro	ayment obligations. Lic ail to correct their non-f	ensee who fail to co iling or delinquency	rrect their nor will be subje	n-
11. Signature and Seal:					
I, say that the statements comy knowledge.*	mamed in this needse app	, being first duly neation are true, complete Signature of Applican in behalf of the Individual	t (Individual or Pers	e best of	
		By:Corporate Officer	(if applicable)		_
Subscribed and sworn to before	re me on this 27	day of December			
My commission expires on _			20 18	, and	
Notary Public P. Koch		(Seal)			
*Note: All information conta	sined in this application m	ust be kept current.			
	KRISTEN P. KC Notary Publi Commonwealth of Mar My Commission En January 19, 20	ic ssachusetts coires			

Rev. 07/01/14