6917

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8
CONCORD, NH 03301-8520
TDD Access: Relay NH 1-800-735-2964
TEL. (603) 271-1203

PLEASE COMPLETE AND RETURN TO THE BOARD OF REGISTRATION IN MEDICINE AS SOON AS POSSIBLE. PLEASE PRINT.

NAME Patricia T. Glowa MD

OFFICE ADDRESS Community Health Center

Buck Rd, Hanover NH 03755 BUSINESS TELEPHONE 603-650-4000

HOME ADDRESS [redacted]

[redacted] HOME TELEPHONE [redacted]

SPECIALTY Family Medicine BOARD CERTIFIED Yes

ALL HOSPITAL AFFILIATIONS Dartmouth-Hitchcock Medical Center

IN WHAT OTHER STATES DO YOU HOLD CURRENT LICENSE Vermont, New York, North Carolina

PLAINS. DHHC
SPEC.

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8
CONCORD, NH 03301-8520

TDD Access: Relay NH 1-800-735-2964

TEL. (603) 271-1203

[redacted]

M.D. REINSTATEMENT APPLICATION

NAME: Patricia T. Glowa, M.D.

HOME ADDRESS: [redacted]

PRESENT PLACE OF PRACTICE: Dept. of Family Medicine, Univ. of North Carolina

ADDRESS: Manning Dr. CB 7595

Chapel Hill, NC 27599-7595 (PHONE) (919) 966-3711

SPECIALTY Family Medicine BOARD CERTIFIED? yes

STATES IN WHICH YOU HOLD OR HAVE EVER HELD LICENSE(S)?
New York, New Hampshire, Vermont, North Carolina
(A verification from any state board from which you hold or have ever held a license stating your license is/was in good standing is required.)

Did you take National Boards, FLEX or USMLE? National Boards

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

2 INDUSTRIAL PARK DRIVE SUITE 8

CONCORD, NH 03301-8520

TDD Access: Relay NH 1-800-735-2964

TEL. (603) 271-1203

NEW HAMPSHIRE BOARD OF REGISTRATION IN MEDICINE

SUPPLEMENT TO APPLICATION

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Patricia T. Glowa MD HOSPITAL: UNC - Memorial Hospitals

PERMANENT ADDRESS: [redacted]

LOCAL MAILING: ADDRESS: Chapel Hill, N.C. 27599

ADDRESS IN (NH): [redacted]

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

		YES	NO
1.	Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? If So How Many ____?	___	✓
2.	Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	___	✓
3.	Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	___	✓
4.	Have you ever failed any of the following examinations: the FLEX examination, any state Board examination or failed to gain certification from the National Board of Medical Examiners?	___	✓

5. Have you ever failed a foreign licensing or certification examination? — ✓

6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason? — ✓

7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? — ✓

8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? — ✓

9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? — ✓

10. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason? — ✓

11. Have you ever, for any reason, lost American Specialty Board Certification? — ✓

12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?_____ — ✓

13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? — ✓

14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time? — ✓

15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine? — ✓

16. Are you now, or have you been in the past, dependent upon alcohol or drugs? ___ ✓

17. Have you ever held a license in New Hampshire or any other state or country? If yes, list other juridsictions. ✓ ___
New Hampshire. Vermont. New York. North Carolina

NOTE ON QUESTIONS 14-16: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #17 please explain on the reverse side. Attach additional 8 1/2" X 11" sheets if necessary.

To the best of my knowledge I meet the qualifications for Full Licensure in New Hampshire.

I hereby certify under the penalty of perjury that all information on this form including attached sheets is true.

NAME (PLEASE PRINT) Patricia T. Glowa MD

SIGNATURE: Patricia T. Glowa MD DATE 7/11/95

1/4/88

Curriculum Vitae

Patricia T. Glowa, MD
[redacted]

UNC/Department of Family Medicine, CB #7595
Chapel Hill, N.C. 27599-7595
(919) 966-3711 ext. 358

Date of Birth: [redacted]
Married:
Children:

Education:

1973-1977	*Harvard Medical School, Boston, Mass., M.D.*
1971-1973	*City College of the City University of New York, New York, N.Y., B.A.*
1967-1970	*McGill University, Montreal, P.Q., Canada, English major*

Post Doctoral Training:

1993-1994	*Faculty Development Fellowship, Department of Family Medicine, UNC-CH*
1979-1980	*Co-Chief Resident, Family Medicine Program, Highland Hospital, Rochester, N.Y.*
1977-1980	*Internship and Residency in Family Medicine, Highland Hospital, Rochester, N.Y.*

Work Experience:

1993-present	*Associate Director, Family Practice Center, Department of Family Medicine UNC-CH*
1992-present	*UNC-Chapel Hill, Department of Family Medicine, Clinical Assistant Professor*
1991-1992	*Haywood Moncure Health Center, Moncure, N.C., practice of family medicine*
1991-present	*Child Medical Evaluation Program, UNC Department of Pediatrics, Chapel Hill, N.C., sexual abuse examiner for State of North Carolina*
1991-1994	*Medical Care Center, Durham, N.C., part-time provider of first-trimester abortions*
1980-1991	*Monroe Clinic, Monroe, N.H., partnership private practice of Family Medicine with Donald Kollisch, M.D.*
1983-1991	*Planned Parenthood of Northern New England, St. Johnsbury, Vt., part-time provider of first-trimester abortions*
1969-1973	*National Emergency Civil Liberties Committee, part- and full-time secretary, executive secretary*

Credentials:
ACLS - 1994
NALS - 1994
Diplomate, American Board of Family Practice, certified 1980, recertified 1986, 1992
North Carolina license for medicine, 1991-present, lic. no. 33831
New Hampshire license for medicine and surgery, 1980-1991, lic. no. 6250
Vermont license for medicine and surgery, 1983-present, lic. no. 6920
New York license for medicine and surgery, 1978-present, lic. no. 134698

Teaching Appointments:

1992-present *Clinical Assistant Professor, Department of Family Medicine, UNC, residency faculty member and team leader*

1991-1992 *Clinical Instructor of Family Medicine, University of North Carolina, 1991-present: resident precepting and medical student instruction*

1980-1991 *Adjunct Assistant Professor of Clinical Community and Family Medicine, Dartmouth Medical School, Office-based teaching of first- and second-year students in the Family Medicine Longitudinal Elective and of third- or fourth-year students in the Primary Care Clerkship*

Research Network Participant:

Primary Care Cooperative Information Project, Dartmouth Medical School, 1981-1991; initiated a study of functional health status in pregnancy, and participated in numerous other studies
Ambulatory Sentinel Practice Network, Denver, Colo., 1983-1991: participated in numerous studies

Memberships:

American Professional Society on the Abuse of Children, 1994-present
Society of Teachers of Family Medicine, 1992-present
American Medical Women's Association, 1992-present
American Academy of Family Practice, 1980-present

Hospital Affiliations:

University of North Carolina Memorial Hospitals, attending staff, 1991-present
Cottage Hospital, Woodsville, N.H., active staff, 1980-1991: President, Medical Staff, 1983
Littleton Hospital, Littleton, N.H. courtesy staff, 1980-1991

Activities:

Center for Development & Learning; Multidisciplinary clinic evaluating LD & Attention Deficit Disorders in adults, Child Development Institute, University of North Carolina, 1994-present
Examiner, Child Medical Evaluation Program, State of North Carolina, 1991-present
Attending Physician of the University of North Carolina Child Medical Evaluation Program (a referral and training clinic on child abuse for the State of North Carolina), 1991-present
Sexual Abuse Team, Division Children & Youth Services, Department of Welfare, Littleton, N.H., 1987-1988
Sexual Abuse Examiner, Division Children & Youth Services, Department of Welfare 1984-1991
Bath School Board, 1982-1991; Chair, 1984-1988, 1990-1991
School Administrative Unit No. 23 Board, member 1982-1991; chair, 1986-1991

Publications:

Practice Commentary on the article; "RU-486, The Progesterone Antagonist", by Barry Weiss, Archives of Family Medicine, Vol. 2, no. 1, 1/93, p. 70.

Article Reviewer:

Archives of Family Medicine, 1994-present

Grant Reviewer:

AAFP/F-AAFP Grant Awards Program

Presentations:
"Breastfeeding: How to Practice What We Preach" Grand Rounds 1/95
"Child Sexual Abuse: The Basics of History & Exam" Principles of Family Medicine 12/94
"Talking with Your Patient About Partner Abuse: Skills Training for Family Practice Residents" STFM, Violence Education Conference, Albuquerque, NM, 11/94
"Change in Resident Knowledge, Attitude, and Practice: An Evaluation of Curriculum on Partner Abuse" STFM, Violence Education Conference, Albuquerque, NM, 11/94
"Teaching About Domestic Violence: What Works?" Faculty Development Fellowship Symposium, University of North Carolina at Chapel Hill, NC 6/94
"Talking with Your Patient About Partner Abuse" Principles of Family Practice 3/94
"Talking about Domestic Violence: Getting Started" Principles of Family Medicine 3/94
"Should Family Physicians Screen for Partner Abuse?" Critical Appraisal Rounds 2/94
"Talking about Domestic Violence: Getting Started" Principles of Family Medicine 2/94
"Physician-Community Interface and the Battered Woman" Grand Rounds 2/94
"Domestic Violence" Grand Rounds 1/94
"Is D & C Necessary for All Miscarriages?" Critical Appraisal Rounds 10/94
"Labor Management Options" Principles of Family Medicine 10/93
"Hypertension" Clinicians Meeting 9/93
"Contraceptive Counseling" Principles of Family Medicine 5/93
"Abortion: Current Realities and Practice in North Carolina", UNC Family Medicine Grand Rounds, 4/93
"Should the Risk of Long-Term Backpain deter the Use of Epidurals in Labor?" Critical Appraisal Rounds 2/93
Functional Health Status in Pregnancy, UNC Family Medicine Grand Rounds, 4/92
"Sexual Abuse: Personal Series"; UNC Family Medicine Grand Rounds, 4/91
Cottage Hospital medical staff education sessions, including Sexual Abuse: Personal Series; Lyme Disease; Abortion and others

Committees:
Sub-Committee on Adolescent Training Programs 1994-Present
Department of Family Medicine:
Team Leaders Council 1992-1993
Practice Management Group 1993-Present
UNC School of Medicine:
Study Committee on Development of Mid-Level Practitioner Training Programs 1993-Present
UNC Memorial Hospital:
Breastfeeding Taskforce 1993-Present

1991 STATE OF NEW HAMPSHIRE 1992
Board of Registration in Medicine

Expires: 6/30/92

APPLICATION FOR ANNUAL REGISTRATION — PHYSICIAN

Please correct mailing address on front of card, if necessary, and complete back of card and return to N.H. Board of Medicine, 6 Hazen Drive, Concord, NH 03301

Fee $75 — Make checks payable to: "TREASURER, STATE OF N.H."

329:16-a Renewal. Every person licensed to practice under this chapter, except as provided in RSA 329:16-b and RSA-329:16-c, shall apply to the board for annual renewal of license on forms provided by the board and shall pay a renewal fee as established by the board. The board may require evidence that the applicant has actually practiced within the state during the previous year, as a condition for renewal.

PATRICIA T GLOWA MD
MONROE CLINIC
P O BOX 180
MONROE NH 03771

Please put on inactive status; home address as of 7/1/91 = [redacted]

PLEASE NOTIFY THIS OFFICE OF ANY CHANGE IN PROFESSIONAL ADDRESS AS REQUIRED BY LAW (RSA 329:16f)
(OVER)

FAILURE TO RENEW ON OR BEFORE JUNE 30, 1991 WILL RESULT IN $25 FINE AND / OR SUSPENSION
IN ACCORDANCE WITH RULES AND REGULATIONS OF THE BOARD

Name: Patricia (First) Todd (Middle) Glowa (Last) Bus. Tel.: 603-638-2372

Office address: Monroe Clinic PO Box 180, Monroe NH 03771 (Street, Town, City, State, Zip Code)

Home Address: [redacted] (Street, Town, City, State, Zip Code)

Are you in active practice? Private: ✓ Other (Specify) Retired?

Please name your specialty: Family Practice

All hospital affiliations: Cottage - active, Littleton - courtesy Inactive

Are you American Board Certified in specialty? yes Name specialty: Family Practice
(If recently acquired, a certified photocopy is required for our files.)

In what other states do you hold a current license to practice medicine (indicate dates of issue) Vermont '83 N.Y. 78, No. Car. '91

Has any state denied your application for license, suspended or revoked your license or informed you of any pending charges? (Yes) (No)

Date: 4/1/91 Signed: Patricia T. Glowa MD

7/15/80
Monroe Clinic
Monroe, N.H. 03771

The State of New Hampshire
Board of Registration in Medicine

Spec. FP
Please Monroe Clinic
7/15/80 Monroe NH

Application No. 6917

I hereby apply* for license to practice Medicine in the State of New Hampshire as a Doctor of Medicine [as a Doctor of Osteopathy] ** and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclose a certified check or postal or express money order for the regular fee of $150.00 (U. S. Funds) No Refunds.

1. **Personal Particulars**

Name in full Patricia Todd Glowa
(Do not use initials) First Middle names in full Last

Present residence: No. [redacted] Street, [redacted]

Post office address (after 7/15/80) c/o Monroe Clinic, Monroe, N.H. 03771
(City or town) (County) (State) Zip Code

Date of birth [redacted], [redacted] Birthplace [redacted]
(City town or county) (State or foreign country)

If foreign born, date and place of naturalization as a citizen of the United States: Date .....1..... Place .....

Age at last birthday [redacted] Sex Female Single, Married, Widowed, or Divorced (*write the word*) Married Color or race white

2. **Academic Education:**

Name and Location of Institutions attended.	Period of Study
McGill University, Montreal, P.Q. Canada	Sept. 1967 - May, 1970
City College of C.U.N.Y., N.Y., N.Y.	Sept. 1971 - June, 1973

Academic degree of B.A., received from City College of N.Y. 1 June, 1973

3. **Medical Education:**

Name and Location of All Institutions attended.	Years attended with Date
Harvard Medical School, Boston, Mass.	Sept. 1973 - June 1977

Degree of Doctor of Medicine [~~Osteopathy~~] received from Harvard Medical School at Boston, Mass. 1 June, 1977

Period and places of practice Family Medicine Residency, Highland Hospital, Rochester, N.Y. July 1977- June 1980

Examined and licensed in the States of New York
(Name all states in which examined or licensed)

4. **Certificate of Medical Education‡:**

It is hereby certified that ..... of .....
matriculated in ..... (Name of institution) at ..... (place)
on ..... 19 ....., attended ..... courses of lectures, and
on ..... 19 ..... received a diploma from this institution conferring the degree of Doctor of Medicine [Osteopathy].

.....
President, Secretary or Dean.

[SEAL] The seal of the institution must be affixed

*This form is to be used for applicants for examination and for applicants for registration without examination.
**In filling out this blank indicate clearly whether the application is for a doctor of medicine or doctor of osteopathy by striking out the appropriate words as indicated herein.
‡ The Board may at its discretion require a slip or leaf from Prospectus of College or School showing what preliminary education is required to enter, and what medical study and standard are required for graduation.

7. **Affidavit of Internship.**

STATE OF New York [SEAL]

County of Monroe ss.

Dr. Donald F. Treat being duly sworn, says that he is Medical Director of the Family Medicine Residency of Highland Hospital located at South Avenue at Bellevue Drive, Rochester, N.Y. and that Patricia T. Glowa M. D. [~~D. O.~~], has been an intern at said hospital at least 12 months from July 1977 to June 1978.

Type of service (~~straight~~ or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine 4 months	Dermatology 30 hours	Pathology
Surgery 1 month	Oto-laryngo-rhinology	Neurology
Obstetrics 2 months	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	Family Medicine - 1 month
Pediatrics 3 months	Psychiatry	Emergency Medicine - 1 month

Donald F. Treat, M. D. ~~[D. O.]~~
(Medical Director) (Chief of Staff)

Sworn to before me this 29th day of May 19 80

Norma N. Zabel Notary Public.
NORMA N. ZABEL
Notary Public in the State of New York
MONROE COUNTY, N. Y.
My Commission Expires March 30, 19 81

(affix seal above [SEAL])

8. **Affidavit of Internship Residency**

STATE OF New York

County of Monroe ss.

Dr. Donald F. Treat being duly sworn, says that he is Medical Director of the Family Medicine Residency of Highland Hospital located at South Avenue at Bellevue Drive and that Patricia T. Glowa M. D. [~~D. O.~~], has been an intern / resident at said hospital from July 1978 to June 1980.

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine 4 months	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology 30 hrs.	Neurology
Obstetrics 4 months	Ophthalmology 30 hours	Clinical laboratory
Gynecology	Roentgenology	Family Medicine 3 1/2 months
Pediatrics 4 months	Psychiatry 4 month	Orthopaedics - 1 month

Cardiology - 60 hours
Geriatrics - 30 hours
Rehabilitation Medicine - 2 months

Donald F. Treat, M. D. ~~[D. O.]~~
(Medical Director) (Chief of Staff)

APR 2 3 1996

STATE OF NEW HAMPSHIRE

Board of Medicine

EXPIRES: 06/30/1997

6917

PATRICIA T GLOWA MD
COMMUNITY HEALTH CENTER
BUCK RD
HANOVER NH 03755-

Please check appropriate mailing address.

Name in full Patricia T Glowa

✓ Place of employment Community Health C
Buck Rd, Hanover N
03

Business Tel: 650-4000

Home Address [redacted]

Home Tel: [redacted]

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY Family Practice BOARD CERTIFIED? yes

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Dartmouth-Hitchcock Medical Center

IN WHAT OTHER STATES DO YOU HOLD LICENSE: N Y, Vt

RENEWAL FEE: $100.00

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES ✓ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES ✓ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Glowa MD
Signature of Licensee (Signature Stamp Not Accepted)

4/11/96
Date

JUN 2 0 1997

STATE OF NEW HAMPSHIRE

Board of Medicine

6917

EXPIRES: 6/30/98

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
2 BUCK RD
HANOVER NH 03755-

Please check appropriate mailing address.

✓

Name in full Patricia T. Glowa M

Place of employment Community Health
2 Buck Rd Hanover NH 03

Business Tel: 603 650-4000

Home Address [redacted]

Home Tel: [redacted]

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

SPECIALTY Family Practice BOARD CERTIFIED? Yes

RENEWAL FEE: $100.00

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: Dartmouth-Hitchcock Medical Center

IN WHAT OTHER STATES DO YOU HOLD LICENSE: Vermont, New York

IN THE PAST 12 MONTHS:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? — 1. ___ YES ✓ NO
2. HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT? — 2. ___ YES ✓ NO
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA? — 3. ___ YES ✓ NO
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? — 4. ___ YES ✓ NO
5. HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE? — 5. ___ YES ✓ NO
6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR? — 6. ___ YES ✓ NO
7. HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT — 7. ___ YES ✓ NO
8. HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING? — 8. ___ YES ✓ NO
9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE? — 9. ___ YES ✓ NO
10. HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM — 10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Glowa
Signature of Licensee (Signature Stamp Not Accepted)

5/27/97
Date

MAY 2 6 19

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/1999

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) (Y)

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)

VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☑ Work Address:

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
2 BUCK RD
HANOVER, NH 03755-

☐ Home Address:

[redacted]

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flores MD
Signature of Licensee (Signature Stamp Not Accepted)

4/29/98
Date

APR 2 7 1999

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2000

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)

VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒

☐

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
2 BUCK RD
HANOVER, NH 03755-
Phone: 603*643-5572

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED - LEBANON NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flora MD
Signature of Licensee (Signature Stamp Not Accepted)

4/15/99
Date

APR 1 3 2000

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2001

Renewal Fee: $100.00

If you do not wish to renew your license, check here. ☐
If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)
VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
2 BUCK RD
HANOVER, NH 03755-
Phone: 603 643-5572

☐ Home Address

[redacted]

Hospital Affiliations: (If not a NH hospital, please list city and state where hospital is located.)

DARTMOUTH-HITCHCOCK MED - LEBANON NH

Concord Hospital, Concord, NH - consulting staff

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?		✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated for use or misuse of any chemical substance?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding?		✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flora
Signature of Licensee (Signature Stamp Not Accepted)

04/03/00
Date

MAY 1 6 2001

FP ck# 510624

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: (date) 6/30/2002

Renewal Fee: $150.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) (Y)

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)

VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
~~2 BUCK RD~~
HANOVER, NH 03755-
Phone: ~~603*643-5572~~
603-650-4000

☐ Home Address

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED - LEBANON NHCONCORD HOSPITAL-CONCORD,NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	X
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated for use or misuse of any chemical substance?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding?	___	X
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flood MD
Signature of Licensee (Signature Stamp Not Accepted)

4/2/01
Date

MAR 2 7 2002

#7421

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2003

Renewal Fee: $150.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)
VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

☐ Home Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
2 BUCK RD
HANOVER, NH 03755-

Family + Community Medicine

[redacted]

Phone: 603*650-4000

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED - LEBANON NH~~CONCORD HOSPITAL - CONCORD NH~~

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	X
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated for use or misuse of any chemical substance?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding?	___	X
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flowa MD
Signature of Licensee (Signature Stamp Not Accepted)

3/4/02
Date

APR 0 3 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

#108285

For expiration on: 06/30/04

Renewal Fee: $150.00

☐ If you **DO NOT** wish to renew your license, check here.

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of ar change in address within 30 days of the change.

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)

VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

☐ Home Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
~~2 BUCK RD~~ 1 Medical Center Dr.
~~HANOVER, NH 03755~~ Lebanon, NH 03766

[redacted]

[redacted]

Phone: 603*650-4000

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MED - LEBANON NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:

	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	X
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding?	___	X
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Flowa MD

Signature of Licensee (Signature Stamp Not Accepted)

3/9/03

Date

MAR 25 2004

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

#139634

RENEWAL APPLICATION

For expiration on: 6/30/06

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, yo will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please ma any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board any change in address within 30 days of the change.**

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)

VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☐ Work Address

☐ Home Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
ONE MEDICAL CENTER DR
LEBANON, NH 03766

[redacted]

[redacted]

Phone: 603*650-4000

[redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege Full	Courtesy	Consult
DARTMOUTH-HITCHCOC	LEBANON	NH	☑	☐	☐
			☒	☒	☒
			☒	☒	☒
			☒	☒	☒
			☒	☒	☒
			☒	☒	☒
			☒	☒	☒

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding?	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Glaser MD — 3/4/09

Signature of Licensee (Signature Stamp Not Accepted) — Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

APR 13 2006

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RECEI
APR 0 5
NH BOA

RENEWAL APPLICATION

#44483

For expiration on: 6/30/08

Renewal Fee: $300.00

06/17/700

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be place on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: FP

Licensed in the states of: (2 letter state abbrev.)
VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
ONE MEDICAL CENTER DR
LEBANON, NH 03766

Phone: 603-650-4000
Business Fax Number: 603-650-4190
Business Email Address: [redacted]

☐ Home Address

[redacted]

Hospital Affiliations: * Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital**

Hospital			Privilege Full	Courtesy	Consult
DARTMOUTH-HITCHCOCK	LEBANON	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	X
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	X
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding?	___	X
9. Have any hospital privileges [redacted] limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Rowan
Signature of Licensee (Signature Stamp Not Accepted)

3/11/06
Date

RECEIVED
MAY 13 2008
MAY 12 2008
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2010

Renewal Fee: $300.00

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT NY

Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250

File #: 6917

☒ Work Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
ONE MEDICAL CENTER DR
LEBANON, NH 03766

Phone: 603*650 4000
Business Fax Number: 603-650-4190
Business Email Address: [redacted]

☐ Home Address

[redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileges been suspended, limited or [redacted] medical records violations, or have you been placed on administrative or medical leave?	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Patricia T. Glover

Signature of Licensee (Signature Stamp Not Accepted)

4/14/08

Date

RECEIVED
MAY 17 2010
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2012

Renewal Fee: $300.00

For Office Use Only:
Date Pd: 5-17-10 Check # 53417

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) VT NY

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 6250 File #: 6917

☒ Work Address

PATRICIA T GLOWA, MD
COMMUNITY HEALTH CENTER
ONE MEDICAL CENTER DR
LEBANON, NH 03766

Phone: 603-650-4000
Business Fax Number: 603-650-4190
Business Email Address: [redacted]

☐ Home Address

[redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each Hospital

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

Please answer each of the following questions. If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	X
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire? New York - no longer needed	X	___
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	X
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report. [redacted]	___	X
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine [redacted] estigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	X
9. Have any hospital privileg[redacted] been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave? [redacted]	___	X
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	X

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the New Hampshire Board of Medicine.**

Patricia T. Flores MD — 4/8/10

Signature of Licensee (Signature Stamp Not Accepted) — Date