SPOA 1421 (REV. 11/94)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400
717-787-2581

Courier Delivery Address
STATE BOARD OF MEDICINE
124 PINE STREET
HARRISBURG, PA 17101

OFFICIAL USE ONLY

MD - 057704 - L

DANTZ APPL

APPLICATION FOR A LICENSE TO PRACTICE MEDICINE WITHOUT RESTRICTION

For Graduates of ACCREDITED Medical Schools

Official Use Only
Amount 20.00
Date 10/19/95

7/29/95

Application Fee: $20.00 *not refundable*

MT-32950-T

Note: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment

Please print or type.

NAME: DANTZIC (Last) SONDRA (First) (Middle)

Permanent Address: [redacted] (Street)

PHILADELPHIA (City) PA (State) 19127 (Zip Code)

Date of Birth: [redacted] Social Security Number: [redacted]

If your medical/licensure records are listed under another name or names list below:

LIST MEDICAL SCHOOL(S) ATTENDED: DATES OF ATTENDANCE

UNIVERSITY OF VERMONT From: 8/89 (Mo.& Yr.) to 5/93 (Mo. & Yr.)

From: _____ (Mo.& Yr.) to _____ (Mo. & Yr.)

Date of Graduation: MAY 1993

List all states, territories and countries in which you have ever possessed a license without restriction to practice medicine and surgery (active or inactive, current or expired). If you never possessed a license, write "NONE."

none

Check licensing examination(s) passed:

(X) FLEX - indicate state where taken: NEW YORK Date taken: JUNE 1993
( ) FLEX COMPONENT 1 - indicate state where taken: _____ Date taken: _____
( ) FLEX COMPONENT 2 - indicate state where taken: _____ Date taken: _____
( ) NATIONAL BOARD - PART I _____ PART II _____ PART III _____
( ) USMLE - STEP 1 _____ STEP 2 _____ STEP 3 _____
( ) LMCC - Canadian
( ) STATE BOARD - indicate state where taken: _____

Post Graduate Education:

PGY1 Hospital: METHODIST HOSPITAL OF PHILADELPHIA From: 6/24/93 to: 6/30/94

PGY2 Hospital: SAME From: 7/1/94 to: 6/30/95

Answer the following questions, if "YES" to any of them, provide complete details on a separate sheet as well as certified copies of relevant documents. Sign and date below.

		YES	NO
1.	Has any disciplinary action been taken against your license in another state, territory or country?	_____	X
2.	Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?	_____	X
3.	Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	_____	X
4.	Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	_____	X
5.	Are you, or have you ever been, addicted to the intemperate use of alcohol or to the habitual use of narcotics or other habit-forming drugs? (Note: You may answer "NO" if you are currently a participant in or have successfully completed the requirements of the Board's Impaired Professional Program.)	[redacted]	

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject to the penalties of 18 Pa. C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my license. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records requested by the Board.

Signature of Applicant: [redacted]

Date: 7/15/95

State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Certification of Moral Character

To be completed by two physicians with a license without restriction in good standing in the United States or Canada.

Name of Applicant: SANDRA DANTZAL

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 2 year(s) _____ month(s).

SIGNATURE: [redacted] Date: 7/13/95

Print or type name as signed above: D. EISENBERGER

State in which licensed: PA License Number: MD056508L

Name of Applicant: SANDRA DANTZAL

I hereby certify that I know the applicant to be of good moral character and to the best of my knowledge, he/she is not addicted to the intemperate use of alcohol or to the habitual use of a narcotic or other habit forming drug. I recommend the applicant for a license to practice medicine in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for 2 year(s) _____ month(s).

SIGNATURE: [redacted] Date: 7/13/95

Print or type name as signed above: ANITA GUZAL

State in which licensed: PA License Number: MD054297-2

Return Completed form to Applicant

Return Completed form to Applicant

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101

2/3094/95

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING

Accredited Medical School Graduates

TO BE COMPLETED BY APPLICANT

NAME: DANTZIC (Last) SONDRA (First) _____ (Middle)

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

Name of Hospital: MEDICAL COLLEGE OF PENNSYLVANIA

Located in: PHILADELPHIA (City) PA (State)

1st Year from 6/25/93 To 6/30/94 Specialty OB&GYN Level(PGY) 1

2nd Year from 7/1/94 To 6/30/95 Specialty OB&GYN Level(PGY) 2

→ "I certify that SONDRA DANTZIC (Name of Applicant) successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

→ ***"I further certify that the above program was ACGME accredited at the time*** SONDRA DANTZIC (Name of Applicant) ***completed the training."***

Signature of Program Director: [signature]

[Seal of Hospital] Date: 7/21/95

If the hospital has no seal complete the following section and have this form notarized:

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____

Date: _____ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE

Entry Level Specialtie

Anesthesiology
Dermatology
Diagnostic Radiology
Emergency Medicine
Family Practice
General Surgery
Internal Medicine
Neurology

The following specialties
to entry and would not b

Adult Reconstructive Su
Aerospace Medicine
Allergy and Immunology
Blood Banking
Cardiovascular Disease
Chemical Pathology
Child Neurology
Child and Adolescent Ps
Colon and Rectal Surge
Critical Care
Dermatopathology
Diagnostic Laboratory I
Endocrinology and Met
Forensic Pathology
Gastroenterology
Geriatrics
Hand Surgery
Hematology
Immunopathology
Infectious Diseases
Medical Microbiology
Medical Oncology
Musculoskeletal Oncolo
Neonatal-Perinatal Med
Nephrology
Neurosurgery
Neuropathology

Board adopted April 2

MEDICAL COLLEGE OF PENNSYLVANIA

A Member of Allegheny Health, Education and Research Foundation

logy

Rehab

d require training prior

me

logy
y/Oncology
y
ics
gy

e/Public Health

s

State Board of Medicine
P.O. Box 2649
Harrisburg, PA
17105-2649

3300 Henry Avenue
Philadelphia, PA 19129

PHILA, PA 191 24 APR 95 #11

Return Completed form to Applicant

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Courier Delivery Address
State Board of Medicine
124 Pine Street
Harrisburg, PA 17101

DS7704

VERIFICATION OF ACGME APPROVED GRADUATE MEDICAL TRAINING
Accredited Medical School Graduates
TO BE COMPLETED BY APPLICANT

NAME: DANTZIC SONDRA
Last First Middle

1. If training began before July 1, 1987, one year of approved training at a first (PGY 1) or second (PGY 2) year level must be verified. If the training began on or after July 1, 1987, two (2) years of approved training are required, one at first (PGY 1) year level and one at second (PGY 2) year level.
2. Training at a first (PGY 1) year must be ACGME approved entry level (training which requires no previous training). Training at a second (PGY 2) year must be ACGME approved and can be any specialty. See listing on back.
3. If training was completed at more than one hospital, duplicate this form and submit to each hospital.

To be completed by the program director at the hospital where the graduate training occurred. If training was in Pennsylvania, information must coincide with data on graduate license. For applicants still in the second year of training, this form may be completed and signed by the program director fifteen (15) days prior to the completion of the approved training. Forms postmarked or signed prior to the fifteen days will not be accepted.

Name of Hospital: Medical College of Pennsylvania

Located in: Philadelphia (City) PA (State) 19127

1st Year from 6/2/93 To 6/30/94 Specialty OB GYN Level(PGY) 1

2nd Year from 7/1/94 To 6/30/95 Specialty OB GYN Level(PGY) 2

→ "I certify that SONDRA DANTZIC (Name of Applicant) successfully completed/will successfully complete this graduate medical training and that there was/is no disciplinary action outstanding against this applicant. If this applicant does not complete this training, the Board will be notified."

→ *"I further certify that the above program was ACGME accredited at the time* Sondra Dantzic (Name of Applicant) *completed the training."*

Signature of Program Director: X Mary Gracie

[Seal of Hospital]

Date: 10/6/95

If the hospital has no seal complete the following section and have this form notarized:

I hereby certify that this hospital has no seal or stamp and that this form was completed by this hospital.

Program Director's Signature: _____

Date: _____ [notary seal]

RETURN COMPLETED FORM DIRECTLY TO THE BOARD IN OFFICIAL HOSPITAL ENVELOPE.

STATE BOARD OF MEDICINE

Entry Level Specialtie

Anesthesiology
Dermatology
Diagnostic Radiology
Emergency Medicine
Family Practice
General Surgery
Internal Medicine
Neurology

The following specialties a
to entry and would not be

Adult Reconstructive Surg
Aerospace Medicine
Allergy and Immunology
Blood Banking
Cardiovascular Disease
Chemical Pathology
Child Neurology
Child and Adolescent Psy
Colon and Rectal Surgery
Critical Care
Dermatopathology
Diagnostic Laboratory Im
Endocrinology and Metab
Forensic Pathology
Gastroenterology
Geriatrics
Hand Surgery
Hematology
Immunopathology
Infectious Diseases
Medical Microbiology
Medical Oncology
Musculoskeletal Oncology
Neonatal-Perinatal Medici
Nephrology
Neurosurgery
Neuropathology

Board adopted April 22, 1

MEDICAL COLLEGE HOSPITALS

Main Clinical Campus

pgy

ehab

require training prior

gy
Oncology
y

ublic Health

STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649

The Federation of State Medical Boards

of the United States, Inc.

400 FULLER WIENER ROAD
EULESS, TEXAS 76039-3855
(817) 868-4000
FAX (817) 868-4099

RECEIVED DIRECT

EXAMINEE: SONDRA S [illegible]

Cindy L. Warner
Administrative Assistant
Pennsylvania State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

It is certified that the above named physician took the Federation Licensing Examination on the date(s) entered below for the State Medical Licensing Board(s) listed and obtained the following scores:

FIN: 631026507 Date of Certification: 10/17/95

DATE OF EXAM	STATE EXAM TAKEN FOR	STATE ID #	COMP 1	COMP 2
06/93	NEW YORK	00320	78	80

COMPONENT 1 of FLEX is designed to evaluate assessable aspects of the knowledge and understanding of basic and clinical sciences, with specific emphasis on principles and mechanisms underlying disease and modes of therapy.

COMPONENT 2 of FLEX is designed to assess the additional cognitive abilities required of physicians who will ultimately assume independent responsibilities for the general health care of patients.

* *

Further automated search of the Federation's Board Action Data Bank reveals no reported information on the above-named physician.

web

SONDRA DANTZIC

[redacted]
Philadelphia, PA 19127
[redacted]

EDUCATION

RESIDENCY, MEDICAL COLLEGE OF PENNSYLVANIA
Philadelphia, Pennsylvania
6/93 - 7/97 (anticipated)
Department of Obstetrics and Gynecology

M.D., UNIVERSITY OF VERMONT COLLEGE OF MEDICINE
Burlington, Vermont
9/89 - 5/93

PRE-MEDICAL COURSES, UNIVERSITY OF MASSACHUSETTS
Amherst, Massachusetts
6/87 - 5/88

B.A., HAMPSHIRE COLLEGE
Amherst, Massachusetts
9/81 - 5/85
Concentration: Psychology and Physiology of Women
Thesis: Bulimia as a Heterogeneous Eating Disorder

RESEARCH EXPERIENCE

RECIPIENT, SUMMER RESEARCH FELLOWSHIP
University of Vermont Committee on Medical Research
6/90 - 9/90
Project: Maximizing Compliance to Breast Cancer Screening Guidelines for Mammograms and Clinical Breast Exams

RESEARCH ASSISTANT
Columbia University, Department of Psychopharmacology and New York State Psychiatric Institute
9/84 - 5/87

CLINICAL EXPERIENCE

SENIOR COUNSELOR
Valley Programs, Inc.
Northampton, Massachusetts
8/88 - 8/89
Deinstitutionalization program for patients with chronic medical and psychiatric illnesses.

FACILITATOR, EATING DISORDERS SUPPORT GROUPS
Amherst College and Hampshire College
9/87 - 5/89

PUBLICATIONS

Walsh BT, Kissileff HR, Cassidy SM, Dantzic S, "Eating Behavior of Women with Bulimia", Archives of General Psychiatry, January 1989, 46:1:54-58.

PROFESSIONAL ORGANIZATIONS

American College of Obstetrics and Gynecology, Junior Fellow
American Medical Women's Association

[redacted]

TARGET SHEET

Board: Medicine

Licensee Full Name:
SONDRA DANTZIC

License No:
MD057704L

607861_LIC_5_04/17/2012

COMMONWEALTH OF PENNSYLVANIA
STATE BOARD OF MEDICINE
P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med

April 17, 2012

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

SONDRA DANTZIC 9849
[redacted]
DOYLESTOWN PA 18901-3127

RE: MD057704L

RE: Continuing Education Audit

Dear Licensee:

The State Board of Medicine received your response to the continuing medical education audit being conducted. The information provided has been reviewed and this hereby certifies your compliance with the continuing medical education requirement for the January 1, 2009 – December 31, 2010 biennial renewal period.

Should you have any questions, please contact the Board.

Sincerely,

State Board of Medicine

CONTINUING EDUCATION APPROVAL SHEET

PROFESSION (PLEASE CHECK)

☒ **MEDICAL PHYSICIAN & SURGEON**

☐ **ATHLETIC TRAINER**

NAME OF CME AUDITOR: Brenda Long

DATE OF REVIEW: 3/30/12

(NOTE: YES OR NO MUST BE CIRCLED)

APPROVED: (YES)

APPROVED: NO

P. O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105
st-medicine@pa.gov
www.dos.state.pa.us/med

January 30, 2012

Telephone: 717-783-1400/787-2381
Fax: 717-787-7769

SONDRA DANTZIC 9849
[redacted]
DOYLESTOWN PA 18901-3127

RE: MD057704L

Dear Doctor:

You have been randomly selected for audit of the continuing education hours claimed for the renewal of your physician and surgeon license through December 31, 2010. The State Board of Medicine requires completion of 100 hours of AMA PRA Category 1 or 2 hours of continuing education as outline below:

- Twenty (20) credit hours must be completed in AMA PRA Category 1 activities.
- The remaining eighty (80) credit hours may be completed in either Category 1 or Category 2 approved activities.
- A minimum of 12 hours of the 100 must be completed in activities related to patient safety or risk management and may be completed in either Category 1 or 2.
- Details regarding continuing education accepted as Category 1 and 2 can be found on the Board's web site at www.dos.state.pa.us/med.

You must now submit **copies** of your continuing education documentation totaling a minimum of 100 hours for the renewal period 1/1/09 through 12/31/10. When submitting Category 1 hours, copies should be 8 ½" x 11" and must include your name, name of sponsor, course title, date of completion and number and category of CME credits awarded. **Do not submit** registration receipts, course agendas, or activity sheets. These do not provide all the information necessary to determine eligibility as outlined above. If you no longer have your certificates, you must contact the course provider for duplicates. **THE DOCUMENTATION SUBMITTED WILL NOT BE RETURNED.**

Please complete the verification statement below and return this entire page with copies of your continuing education documentation **no later than 30 days from the date of this audit notice**. If you were exempt from the CME requirement during the required time period, please complete and return this audit notice with documentation of your exemption.

Failure to satisfactorily comply with this audit request will result in a referral to the Professional Compliance Office, which may result in disciplinary proceedings under **Section 41 (6) of the Medical Practice Act of 1985 (63 P.S. 422.41 (6).** Thank you for your cooperation.

Sincerely,
State Board of Medicine

VERIFICATION STATEMENT

I have attached copies of approved continuing education for programs I completed during the licensure period 1/1/09 through 12/31/10

[redacted]

Signature (Required)

3-18-12
Date

MAR 23 2012

UNIVERSITY OF MINNESOTA

Medical School

Statement of Attendance

Sondra Dantzic MD
[redacted]
Doylestown, PA 18901

Advanced Mind-Body Medicine Professional Training Program

January 31 – February 4, 2009
Minneapolis Marriott City Center
Minneapolis, MN

American Medical Association/Physician Recognition Award
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the University of Minnesota and the Center for Mind-Body Medicine. The University of Minnesota is accredited by the ACCME to provide continuing medical education for physicians.

The University of Minnesota designates this educational activity for a maximum of **29.75** *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

American Academy of Physician Assistants
AAPA accepts AMA Category 1 CME credit for the PRA from organizations accredited by ACCME.

Other Health Care Professionals
Other health care professionals who participate in this CME activity may submit their Statements of Attendance to their appropriate accrediting organizations or state boards for consideration of credit. The participant is responsible for determining whether this activity meets the requirements for acceptable continuing education.

Ginny Jacobs, M.Ed., MLS, CCMEP
Director, Continuing Medical Education
University of Minnesota Medical School

Office of Continuing Medical Education
University Park Plaza, Suite 601
2829 University Avenue, SE
Minneapolis, MN 55414

Phone: 612-626-7600
FAX: 612-626-7766
Web: www.cme.umn.edu

Number of Credits Claimed: 29.75

Please retain this statement for your records. Replacement copies can be obtained for a $25 service fee.

MAR 9 8 2012

American Society for Colposcopy and Cervical Pathology

Founded 1964

Devoted to the Study of Early Cervical Neoplasia

The American Society for Colposcopy and Cervical Pathology (ASCCP) certifies that

Sondra Dantzic, MD

has participated in the educational activity titled *2010 ASCCP Biennial Meeting* and its ancillary CME workshops at the Green Valley Ranch Resort in Las Vegas, Nevada on March 24-27, 2010.

The American College of Obstetricians and Gynecologists has assigned 29 cognate credits to this program.

Actual ACOG cognate credits this participant claims: 21

MAR 2 3 2012

PRESIDENT

EDUCATION CHAIR

This is your Official Certificate of Completion. Please print for your records.
To Print Press Button Below.

P5

Please click here to refer this program to your colleagues

CERTIFICATE OF COMPLETION

INFORMED certifies that

SONDRA BETH DANTZIC

has participated in the educational activity titled

2008-2009 Physician Update: Cultural Competency

on

June 20, 2009

and is awarded 7 *AMA PRA Category 1 Credit(s).*™

InforMed is approved by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing education for physicians.

William J. Ruff

Director, Program Administration

The correct answers to the test questions:							
1	A	11	C	21	A	31	B
2	B	12	B	22	A	32	A
3	False	13	D	23	D	33	D
4	True	14	B	24	A	34	B
5	A	15	B	25	A	35	C
6	A	16	B	26	B	36	C
7	D	17	B	27	B		
8	D	18	B	28	C		
9	C	19	E	29	A		
10	C	20	B	30	C		

Your answers missed
15

MAR 23 2012

This is to certify that

Sondra Dantzic, MD

has attended, in its entirety, the

Family Violence Prevention Fund's

Assessment and Intervention for Reproductive Control

in New York, NY
August 12, 2009

3 *total hours/credits*

Esta Soler

Esta Soler, President, Family Violence Prevention Fund

September 20, 2009
Date

The Family Violence Prevention Fund's National Health Resource Center on Domestic Violence is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. FVPF certifies that this continuing medical education activity meets the criteria for a maximum of 3 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

ABO+G

Kenneth L. Noller, M.D.
Director of Evaluation
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: [redacted]
Fax: (214) 871-1943

March 9, 2012

Sondra Beth Dantzic, M.D.
589 Christopher Lane
Doylestown, PA 18901

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2009 Maintenance of Certification assignments. You have **earned 35 AMA** Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists (ACOG).

Documentation of completion of the MOC process will be furnished to the engraving company.

Your certification status in Obstetrics and Gynecology on March 9, 2012 is "active". The MOC process requires a new application and participation each year.

Please use this letter to provide documentation of your status for your hospitals. Please remember that you must re-apply for MOC each year. The application for the 2010 MOC process will be available through your ABOG Member Login page beginning in November, 2009 .

Sincerely yours,

[redacted]
Kenneth Noller, M.D.
Director of Evaluation

KLN

ABOG ID: 970737

MAR 23 2012

A057978

ABO+G

Kenneth L. Noller, M.D.
Director of Evaluation
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: [redacted]
Fax: (214) 871-1943

March 9, 2012

[redacted]
Sondra Beth Dantzic, M.D.
589 Christopher Lane
Doylestown, PA 18901

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2010 Maintenance of Certification Part II assignments. You have earned **35 AMA** Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists (ACOG).

Documentation of completion of the MOC process will be furnished to the engraving company.

Your certification status in Obstetrics and Gynecology on March 9, 2012 is "active". The MOC process requires a new application and participation each year.

Please use this letter to provide documentation of your status for your hospitals. Please remember that you must re-apply for MOC each year. The application for the 2011 MOC process will be available through your ABOG Member Login page beginning in November, 2010 .

Sincerely yours,

[redacted]

Kenneth Noller, M.D.
Director of Evaluation

KLN

ABOG ID: 970737

[redacted]

MAR 23 2012

A057978

CERTIFICATE OF ATTENDANCE

NATIONAL ABORTION FEDERATION

NAF's 34th Annual Meeting
Liberty, Justice and Abortion

April 26-27, 2010 **Philadelphia, Pennsylvania**

The National Abortion Federation (NAF) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

NAF certifies that

SONORA DANTZIC, MD

(Name of participant)

Has participated in the educational activity titled "NAF's 34th Annual Meeting—Liberty, Justice and Abortion" on April 26–27, 2010. This activity was designated for a maximum of 12 AMA PRA Category 1 Credits.™

Many states require documentation of continuing education for licensure renewal for nurses and other professionals. This certificate is your documentation of attendance. Individuals with professional degrees should contact their state licensing Board to determine the acceptability of AMA PRA Category 1 Credits.™

Vicki Saporta
President and CEO

Sally Burgess
Sally Burgess, MBA
Chair of the Board of Directors

MAR 23 2012

SONDRA DANTZIC
[redacted]
DOYLESTOWN, Pennsylvania 18901.

INFORMED

Certificate of Completion

This Certifies that
Name: SONDRA DANTZIC License #: MD057704L
Has participated in the Enduring Material activity titled:
2012-2013 Pennsylvania Patient Safety Update
Patient Safety Update, Self-Directed Learning, the Internet, and CME

and is awarded 13 *AMA PRA Category 1 Credit(s)* ™

Date of Completion: 3/20/2012

William J. Ratliff
Director, Program Administration

Score Information

88 %

Correct answers are:

1. C 2. C 3. A 4. B 5. D 6. B 7. A 8. B 9. A 10. A
11. A 12. C 13. A 14. B 15. D 16. B 17. C 18. A 19. D 20. C
21. A 22. C 23. A 24. B 25. A 26. A 27. B 28. D 29. C 30. C
31. C 32. D 33. B 34. A 35. C 36. B 37. A 38. D 39. B 40. C
41. C

Wrong answered questions are: 4,5,24,38

Payment Information
Card Used: Visa Amount: $ 75.00 Date: 3/20/2012

MAR 23 2012

Person Info
Name:SONDRA DANTZIC
Address Info
Street Address: [redacted] **Email:** [redacted]@verizon.net
Phone [redacted]
Fax
CityDoylestown
StatePA
Zipcode189013127
Country82
CountyBucks

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Do you hold a license/certificate (active, inactive or expired) to practice in any other state or jurisdiction?	Y
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against your license, certificate or registration issued to you in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict, or accelerated rehabilitative disposition(ARD) as to any felony or misdemeanor, including any drug law violations, or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a license, certificate or registration, had an application denied or refused, or for disciplinary reasons agreed not to reapply for a license, certificate or registration in any profession in any other state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?	N
Since your last renewal, have you been the subject of a civil malpractice law suit? If yes, please submit a copy of the entire Civil Complaint which must include the filing date and the date you were served. If you previously reported the complaint, email or fax the docket number to	N

the Board. (email at st-medicine@state.pa.us or fax at 717-787-7769)	
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or last renewal, whichever is later, have you had practice privileges denied, revoked or restricted in a hospital or health care facility?	N
Since your initial application or last renewal, whichever is later, have your provider privileges been denied, revoked or restricted by any medical assistance agency for cause?	N
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
Have you met your current CE requirements?	Y

Education Information

No education records

Employment Information

No employment records

remarks

Remarks:

Continuing Education Information

No CE Course records

Person Info
Name: SONDRA DANTZIC
Address Info

Street Address [redacted] **Email** [redacted]@verizon.net
Phone [redacted]
Fax
City Doylestown
State PA
Zipcode 189013127
Country 82
County Bucks

Survey Response Summary
Question Response Summary

Are you submitting a name change with this renewal?	N
Have you met your current CE requirements?	Y
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice a profession or occupation in any state or jurisdiction?	Y
If you answered yes to the above questions, please provide the profession and state or jurisdiction.	NY, NJ
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
If yes, are you currently participating in the Pennsylvania Professional Health Monitoring Program?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	N
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. Submit a statement which includes complete details of the complaints that have been filed against you. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	N
If you answer "No", please provide an explanation or reason for an exemption request.	Exempt because not practicing in PA

Date Submitted: Tuesday, December 30, 2014

Education Info

No education records

Employment Information

No employment records

Person Info
Name: SONDRA DANTZIC
Address Info
Street Address: [redacted]
Email: [redacted]@gmail.com
Phone [redacted]
Fax
City Doylestown
State PA
Zipcode 189013127
Country 82
County Bucks

Survey Response Summary

Question Response Summary

Are you submitting a name change with this renewal?	N
Have you completed your current CE requirements?	Y
Do you hold, or have you ever held, a license, certificate, permit, registration or other authorization to practice any health-related profession in any state or jurisdiction?	Y
If you answered yes to the above question, please provide the profession and state or jurisdiction.	PA, NY, NJ
Since your initial application or last renewal, whichever is later, have you had disciplinary action taken against a professional or occupational license, certificate, permit, registration or other authorization to practice a profession or occupation issued to you in any state or jurisdiction or have you agreed to voluntary surrender in lieu of discipline?	N
Do you currently have any disciplinary charges pending against your professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you withdrawn an application for a professional or occupational license, certificate, permit or registration, had an application denied or refused, or for disciplinary reasons agreed not to apply or reapply for a professional or occupational license, certificate, permit or registration in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you been convicted (found guilty, pled guilty or pled nolo contendere), received probation without verdict or accelerated rehabilitative disposition (ARD), as to any criminal charges, felony or misdemeanor, including any drug law violations? Note: You are not required to disclose any ARD or other criminal matter that has been expunged by order of a court.	N
Do you currently have any criminal charges pending and unresolved in any state or jurisdiction?	N
Since your initial application or last renewal, whichever is later, have you had your DEA registration denied, revoked or restricted?	N
Since your initial application or your last renewal, whichever is later, have you had provider privileges denied, revoked, suspended or restricted by a Medical Assistance agency, Medicare, third party payor or another authority?	N
Since your initial application or your last renewal, whichever is later, have you ever had practice privileges denied, revoked, suspended, or restricted by a hospital or any health care facility?	N
Since your initial application or your last renewal, whichever is later, have you been charged by a hospital, university, or research facility with violating research protocols, falsifying research, or engaging in other research misconduct?	N
Since your initial application or last renewal, whichever is later, have you engaged in the intemperate or habitual use or abuse of alcohol or narcotics, hallucinogenics or other drugs or substances that may impair judgment or coordination?	[redacted]
Since your initial application or your last renewal, whichever is later, have you been the subject of a civil malpractice lawsuit?	Y
If yes, please submit a copy of the entire Civil Complaint, which must include the filing date and the date you were served. PLEASE NOTE: If you previously reported the complaint to the Board you will only need to provide the docket number here:	
Have you completed 2 hours of Board-approved continuing education in child abuse recognition and reporting?	Y
Do you maintain current medical professional liability insurance in the Commonwealth of Pennsylvania?	Y
If you answer "No", please provide an explanation or reason for an exemption request.	
Please provide the zip code of your primary employer/practice location. This data is being collected for the purpose of identifying healthcare professionals during state emergencies and may be provided to the Pennsylvania Emergency Management Agency for official use only.	18106

Date Submitted: Thursday, December 01, 2016

Education Info

No education records

Employment Information

No employment records

Official Use Only 037031

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD - 057704 - L

DANTZ RNEW

THIS IS YOUR RENEWAL NOTICE

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

SONDRA DANTZIC
[redacted]
PHILADELPHIA, PA 19127

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1996. TO RENEW THROUGH DECEMBER 31, 1998 PLEASE COMPLETE THE QUESTIONS BELOW AND SUBMIT A CHECK OR MONEY ORDER IN THE AMOUNT OF $80.00, MADE PAYABLE TO THE "COMMONWEALTH OF PA." RECORD YOUR LICENSE NUMBER ON THE FRONT OF YOUR PAYMENT. A LATE PENALTY FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1996. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE AND ATTACH A COPY OF LEGAL DOCUMENTATION OF THE NAME CHANGE.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, PLEASE PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY.

YES	NO		
( )	(X)	1.	DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE ON THE BACK.
( )	(X)	2.	SINCE YOUR LAST RENEWAL, HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOUR LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY?
( )	(X)	3.	SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY OR NOLO CONTENDERE, OR RECEIVED PROBATION WITHOUT VERDICT AS TO ANY FELONY OR MISDEMEANOR, INCLUDING ANY DRUG LAW VIOLATION, IN ANY STATE OR FEDERAL COURT?
( )	(X)	4.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED OR RESTRICTED IN A HOSPITAL OR OTHER HEALTH CARE FACILITY?
( )	(X)	5.	SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTIONS ABOVE.

SIGN AND DATE BELOW AND PROVIDE THE REQUESTED INFORMATION

SOCIAL SECURITY NUMBER [redacted] DATE OF BIRTH [redacted]

NAME OF MEDICAL SCHOOL UNIVERSITY OF VERMONT YEAR OF GRADUATION 91

I CERTIFY THAT THE INFORMATION CONTAINED IN THIS APPLICATION IS TRUE AND CORRECT UNDER 18 PA. C.S. SECTION 4904 RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE [redacted] DATE 10-21-96

000802

Official Use Only 033040

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD - 057704 - L

DANTZ RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

SONDRA DANTZIC
[redacted]
PHILADELPHIA, PA 19127

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 1998. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2000, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $6.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 1998. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE ERR PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO
( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE BELOW.
( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?
( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (INCLUDING ACQUITTAL OR DISMISSAL) WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATION, IN THE STATE OR FEDERAL COURTS? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)
( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.
( ) (X) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES LIMITED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?
( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION. SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE [redacted] DATE 11/4/98

00002032

Official Use Only 029779

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS

MD - 057704 - L

DANTZ RNEW

THIS IS YOUR RENEWAL NOTICE - REQUIRED FEE - $125.00

STATE BOARD OF MEDICINE
P.O. BOX 8414
HARRISBURG, PA. 17105-8414

SONDRA DANTZIC
[redacted]
DOYLESTOWN, PA 18901

YOUR CURRENT LICENSE TO PRACTICE MEDICINE AND SURGERY IN PENNSYLVANIA WILL EXPIRE ON DECEMBER 31, 2000. TO RENEW YOUR LICENSE THROUGH DECEMBER 31, 2002, COMPLETE THE QUESTIONS BELOW AND RETURN WITH A CHECK OR MONEY ORDER IN THE AMOUNT OF $125.00 MADE PAYABLE TO THE "COMMONWEALTH OF PA." WRITE YOUR LICENSE NUMBER ON THE FRONT OF THE PAYMENT. A LATE FEE OF $5.00 PER MONTH WILL BE CHARGED FOR RENEWALS POSTMARKED AFTER DECEMBER 31, 2000. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER UNPAID BY YOUR BANK, REGARDLESS OF THE REASON. IF YOU HAVE A CHANGE IN NAME AND/OR ADDRESS, INDICATE THE CHANGE NEXT TO THE PRE-PRINTED NAME AND ADDRESS ABOVE. A NAME CHANGE REQUIRES SUBMISSION OF A COPY OF A COURT ORDER, MARRIAGE CERTIFICATE, DIVORCE DECREE OR OTHER OFFICIAL DOCUMENT.

NOTICE: IF YOU PRACTICE IN PENNSYLVANIA, YOU MUST MAINTAIN THE REQUIRED AMOUNT OF PROFESSIONAL LIABILITY INSURANCE AND PAY THE REQUIRED FEE AND CAT FUND SURCHARGE. FAILURE TO DO SO WILL RESULT IN SUSPENSION OR REVOCATION OF YOUR LICENSE.

ANY DISCIPLINARY ACTION TAKEN IN ANOTHER STATE, TERRITORY OR COUNTRY SHALL BE REPORTED TO THE BOARD ON THE BIENNIAL RENEWAL NOTICE OR WITHIN 30 DAYS OF FINAL DISPOSITION, WHICHEVER IS SOONER.

THE FOLLOWING QUESTIONS MUST BE ANSWERED. IF YOU ANSWER "YES" TO QUESTIONS 2, 3, 4, OR 5 BELOW, YOU MUST PROVIDE COMPLETE DETAILS ON 8 1/2 X 11 SHEETS OF PAPER AND INCLUDE COPIES OF LEGAL DOCUMENTS, IF ANY. FAILURE TO PROVIDE DOCUMENTS WILL DELAY THE PROCESS.

YES NO

( ) (X) 1. DO YOU HOLD A LICENSE TO PRACTICE MEDICINE AND SURGERY (ACTIVE OR INACTIVE, CURRENT OR EXPIRED) IN ANY OTHER JURISDICTION? IF YES, LIST EACH ONE. _____

( ) (X) 2. SINCE YOUR LAST RENEWAL, HAS ANOTHER STATE, TERRITORY OR COUNTRY TAKEN ANY DISCIPLINARY ACTION (INCLUDES VOLUNTARY SURRENDER OF A LICENSE) AGAINST YOU OR FILED CHARGES AGAINST YOU THAT HAVE NOT BEEN RESOLVED IN YOUR FAVOR?

( ) (X) 3. SINCE YOUR LAST RENEWAL, HAVE YOU BEEN CONVICTED, FOUND GUILTY, PLEADED NOLO CONTENDERE, RECEIVED PROBATION WITHOUT VERDICT, OR RECEIVED ANY OTHER DISPOSITION (EXCLUDING ACQUITTAL OR DISMISSAL), WITH RESPECT TO ANY CRIMINAL OFFENSE, INCLUDING ANY DRUG LAW VIOLATIONS, OR DO YOU HAVE ANY CRIMINAL CHARGES PENDING AND UNRESOLVED IN ANY STATE OR FEDERAL COURT? (A SUMMARY TRAFFIC VIOLATION SHOULD NOT BE CONSIDERED AS A CRIMINAL OFFENSE.)

( ) (X) 4. SINCE YOUR LAST RENEWAL, FOR DISCIPLINARY REASONS HAVE YOU WITHDRAWN AN APPLICATION FOR A LICENSE, HAD AN APPLICATION FOR A LICENSE DENIED OR REFUSED, OR AGREED NOT TO REAPPLY FOR A LICENSE IN ANOTHER STATE, TERRITORY OR COUNTRY? A LICENSE INCLUDES A REGISTRATION OR CERTIFICATION.

( ) (X) 5. SINCE YOUR LAST RENEWAL, HAVE YOU HAD PRACTICE PRIVILEGES DENIED, REVOKED, SUSPENDED, RESTRICTED, SURRENDERED IN LIEU OF DISCIPLINE OR EMPLOYMENT TERMINATED IN A HOSPITAL OR ANY HEALTH CARE FACILITY?

( ) (X) 6. SINCE YOUR LAST RENEWAL, HAVE YOU HAD YOUR DEA REGISTRATION DENIED, REVOKED OR RESTRICTED OR HAVE YOU HAD YOUR PROVIDER PRIVILEGES TERMINATED BY ANY MEDICAL ASSISTANCE AGENCY FOR CAUSE?

IF YOU WANT YOUR LICENSE PLACED ON "INACTIVE" STATUS PLACE AN "X" IN THE BLANK TO THE RIGHT. _____
NO FEE IS REQUIRED. YOU ARE STILL REQUIRED TO ANSWER THE QUESTION, SIGN AND DATE BELOW.

MY REPRESENTATIONS AND RESPONSES IN THIS DOCUMENT ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THEY ARE SUBJECT TO THE PENALTIES OF 18 PA. C.S. 4904, RELATING TO UNSWORN FALSIFICATION TO AUTHORITIES.

SIGNATURE [redacted] DATE 10.2.00

00000734

9466

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE

MD057704L
Renewal ID : 510649
DANTZIC

RENEWAL APPLICATION - MD

SONDRA DANTZIC
[redacted]
DOYLESTOWN PA 18901-3127

RETURN TO:

State Board of Medicine
PO Box 8414
Harrisburg, PA 17105-8414

Important Information

You can now renew your license online by pointing your browser to www.myLicense.state.pa.us and following the instructions as indicated. Your license renewal will be processed easier and quicker than by mail.

☐ I will not be practicing this profession in Pennsylvania after the expiration date indicated below and request inactive status. **No fee is required. Renewal must still be completed – questions answered, signed and dated.**

☐ I am retired from practice but desire to keep my license active to treat immediate family members. I am exempt from the medical professional liability insurance and CME requirements. **Renewal must be completed and fee required.**

Name Change	Address Change
Indicate new name below. Submit a photocopy of a legal document verifying name change. (i.e., marriage certificate, divorce decree or legal document indicating retaking of a maiden name, etc.)	

THE FOLLOWING QUESTIONS MUST BE ANSWERED

YES	NO	If YES to question 2, 3, 4, 5, 6, 7 or 8 – provide details AND attach certified copies of legal document(s).
✓		1. Do you hold a license (active, inactive or expired) to practice in any other state or jurisdiction? List NEW JERSEY
	✓	2. **Since your initial application or your last renewal,** have you had disciplinary action taken against your license in any other state or jurisdiction?
	✓	3. **Since your initial application or your last renewal,** have you withdrawn an application for a license, had an application for a license denied or refused, or agreed not to reapply for a license in any state or jurisdiction?
	✓	4. **Since your initial application or your last renewal,** have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violations, or any criminal charges pending and unresolved in any state or jurisdiction?
	✓	5. **Since May 19, 2002,** have you been arrested for criminal homicide, aggravated assault, sexual offenses or drug offenses in any state, territory or country?
	✓	6. **Since your initial application or your last renewal,** have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?
	✓	7. **Since your initial application or your last renewal,** have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?
	✓	8. **Since May 19, 2002,** have any malpractice complaints been filed against you?
	✓	9. I am in compliance with the professional liability insurance requirements under Section 711 of the Medical Care Availability and Reduction of Error (MCare) Act No. 13 of 2002.

I verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. 4911 and that any false statement made is subject to the penalties of 18 PA C.S. 4904 relating to unsworn falsification to authorities and may result in my license being disciplined.

Signature of Licensee (Mandatory) [redacted] Date 11/26/02

EXPIRATION DATE:	**December 31, 2002**
FEE – Payable to "COMMONWEALTH OF PENNSYLVANIA" Write your license number on your payment. A $20.00 fee will be assessed for returned payment.	**$360.00** **MD057704L**
LATE FEE - $5.00 per month, or part of a month Late renewal fee will be assessed if postmarked after December 31, 2002	**PRACTICING ON AN EXPIRED LICENSE MAY RESULT IN DISCIPLINARY ACTIONS AND ADDITIONAL MONETARY PENALITIES**

BPOA 1615 (REV. 1/93)

Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400
717-787-2381

Courier Delivery Address
State Board of Medicine
Rm 612, Transportation & Safety Bldg.
Commonwealth Ave. & Forster St.
Harrisburg, PA 17120

OFFICIAL USE ONLY

MT - 032952 T

DANTZAPPL [

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE - DO NOT USE TO RENEW

NOTE: A processing fee of $20.00 will be charged for any check or money order returned unpai your bank, regardless of the reason for non-payment.

FEE - $15.00

MAKE FEE PAYABLE TO COMMONWEALTH OF PENNSYLVANIA

FEE NOT REFUNDABLE

THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO START OF TRAINING

Official Use Only

Amount $15

Date 9.1.93

TO BE COMPLETED BY APPLICANT:

Please Print or Type

NAME: DANTZIC (LAST) SONDRA (FIRST) BETH (MIDDLE) (MAIDEN)

ADDRESS: [redacted] (STREET)

BURLINGTON (CITY) VT (STATE) 05401 (ZIP CODE)

SOCIAL SECURITY #: [redacted] 11-772-93 (MED ID)

DATE OF BIRTH: [redacted] (MONTH/DATE/YEAR)

TELEPHONE NUMBERS: [redacted]

NAME & ADDRESS OF MEDICAL SCHOOL	DATES OF ATTENDANCE	DATE OF GRADUATION
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE	8-89 -	5-93

NAME & ADDRESS OF HOSPITAL(S)	DATES OF PREVIOUS TRAINING	SPECIALTY
NONE		

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: Medical College Hospitals, Main Clinical Campus HS-- 140-2

ADDRESS OF HOSPITAL 3300 Henry Avenue, Philadelphia, PA 19129

YEAR IN TRAINING: 1st SPECIALTY: Obstetrics and Gynecology (OB/G) LEVEL IN TRAINING (1)

DATES OF TRAINING REQUESTED: June 21, 1993 (BEGINNING DATE-MONTH-DAY-YEAR) TO June 21, 1994 (ENDING DATE-MONTH-DAY-YEAR)

NAME OF PROGRAM DIRECTOR: Glenda Donoghue M.D., Assoc. Dean for Post Graduate Med. Educ.

Glenda Donoghue MD Glenda K. Donoghue MD 6/15/93

List all states, territories and countries in which you have ever possessed a license to practice medicine and surgery (active or inactive, current or expired).

All of the questions must be answered. You must sign and date this form before returning it to be processed.

If you answer "YES" to any of the questions, you must provide complete data on a separate 8 1/2 x 11 sheet.

	YES	NO
1. Has any disciplinary action been taken against your license in another state, territory or country?	____	✓
2. Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?	____	✓
3. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	____	✓
4. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	____	✓

I SONDRA DANTZIC being duly sworn according to law, depose and say I am the
PRINT NAME OF APPLICANT
person completing this application, that I am of good moral character, and that all statements therein are true and complete to the best of my knowledge and belief. I hereby authorize hospitals, institutions or organizations, my references, personal physicians, employers (past & present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Pennsylvania State Board of Medicine any information, files or records required by the Board.

Signature of Applicant: [redacted]

Date: 3-27-93

SONDRA DANTZIC

[redacted]
Burlington, Vermont 05401
[redacted]

EDUCATION

M.D., UNIVERSITY OF VERMONT COLLEGE OF MEDICINE
Burlington, Vermont
9/89 - 5/93 (anticipated)

PRE-MEDICAL COURSES, UNIVERSITY OF MASSACHUSETTS
Amherst, Massachusetts
6/87 - 5/88

B.A., HAMPSHIRE COLLEGE
Amherst, Massachusetts
9/81 - 5/85
Concentration: Psychology and Physiology of Women
Thesis: Bulimia as a Heterogeneous Eating Disorder

RESEARCH EXPERIENCE

RECIPIENT, SUMMER RESEARCH FELLOWSHIP
University of Vermont Committee on Medical Research
6/90 - 9/90
Project: Maximizing Compliance to Breast Cancer Screening Guidelines for Mammograms and Clinical Breast Exams

RESEARCH ASSISTANT
Columbia University, Department of Psychopharmacology and New York State Psychiatric Institute
9/84 - 5/87

CLINICAL EXPERIENCE

SENIOR COUNSELOR
Valley Programs, Inc.
Northampton, Massachusetts
8/88 - 8/89
Deinstitutionalization program for patients with chronic medical and psychiatric illnesses.

FACILITATOR, EATING DISORDERS SUPPORT GROUPS
Amherst College and Hampshire College
9/87 - 5/89

PUBLICATIONS

Walsh BT, Kissileff HR, Cassidy SM, Dantzic S. "Eating Behavior of Women with Bulimia." Archives of General Psychiatry, January 1989; 46:1:54-58.

HONORS

Maternal Fetal Medicine (AI), Obstetrics and Gynecology, Psychiatry

PROFESSIONAL ORGANIZATIONS

American Medical Women's Association
President, UVM Medical Student Chapter, 1990 and 1991
Attended National Conference, 1990

American Medical Association

3 1 2 4 7 0 6 1 3

SPCA 1615 (REV. 1/93)

Regular Mailing Address
State Board of Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649
717-783-1400
717-787-2381

Courier Delivery Address
State Board of Medicine
Rm 612, Transportation & Safety Bldg.
Commonwealth Ave. & Forster St.
Harrisburg, PA 17120

OFFICIAL USE ONLY

MT - 032952 [redacted]

DANT2 APPL [redacted]

APPLICATION FOR A GRADUATE LICENSE FOR GRADUATES OF ACCREDITED MEDICAL SCHOOLS

THIS APPLICATION IS TO BE USED FOR INITIAL GRADUATE LICENSE - DO NOT USE TO RENEW

NOTE: A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason for non-payment.

FEE - $15.00

MAKE FEE PAYABLE TO COMMONWEALTH OF PENNSYLVANIA

FEE NOT REFUNDABLE

THIS APPLICATION MUST BE SUBMITTED AT LEAST 60 DAYS PRIOR TO START OF TRAINING

Official Use Only

Amount 115

Date

TO BE COMPLETED BY APPLICANT:

Please Print or Type

NAME: DANTZIC (LAST) SONDRA (FIRST) BETH (MIDDLE) (MAIDEN)

ADDRESS: [redacted] (STREET)

BURLINGTON (CITY) VT (STATE) 05401 (ZIP CODE)

SOCIAL SECURITY # [redacted]

DATE OF BIRTH: [redacted] (MONTH/DATE/YEAR)

TELEPHONE NUMBERS: [redacted]

NAME & ADDRESS OF MEDICAL SCHOOL: UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

DATES OF ATTENDANCE: 8-89 - 5

DATE OF GRADUATION: 5-93

NAME & ADDRESS OF HOSPITAL(S): NONE

DATES OF PREVIOUS TRAINING:

SPECIALTY:

TO BE COMPLETED BY HOSPITAL LOCATED IN PENNSYLVANIA:

NAME OF HOSPITAL: Medical College Hospitals Main Clinical Campus DO- 1H0-L

ADDRESS OF HOSPITAL: [redacted] Henry Avenue, Philadelphia, PA 19129

YEAR IN TRAINING: 1st

SPECIALTY: Obstetrics and Gynecology

LEVEL IN TRAINING: I

DATES OF TRAINING REQUESTED: June 21 1993 (BEGINNING DATE-MONTH-DAY-YEAR) TO June 21, 1994 (ENDING DATE-MONTH-DAY-YEAR)

NAME OF PROGRAM DIRECTOR: Glenda Donoghue M.D., Assoc. Dean for Post Graduate Med. Educ

SIGNATURE OF PROGRAM DIRECTOR: Glenda Donoghue MD

List all states, territories and countries in which you have ever possessed license to practice medicine and surgery (active or inactive, current or expire

---

All of the questions must be answered. You must sign and date this form bef returning it to be processed.

If you answer "YES" to any of the questions, you must provide complete deta on a separate 8 1/2 x 11 sheet.

	YES	NO
1. Has any disciplinary action been taken against your license in another state, territory or country?	___	✓
2. Have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court?	___	✓
3. Have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	___	✓
4. Have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	___	✓

I SONDRA DANTZIC being duly sworn according to law, depose and say I am
PRINT NAME OF APPLICANT
person completing this application, that I am of good moral character, and that all statame therein are true and complete to the best of my knowledge and belief. I hereby authorize hospitals, institutions or organizations, my references, personal physicians, employers (past present), and all governmental agencies and instrumentalities (local, state, federal or forei to release to the Pennsylvania State Board of Medicine any information, files or records requer by the Board.

Signature of Applicant: [redacted]

Date: 3-27-93

SONDRA DANTZIC

[redacted]

Burlington, Vermont 05401

[redacted]

EDUCATION

M.D., UNIVERSITY OF VERMONT COLLEGE OF MEDICINE
Burlington, Vermont
9/89 - 5/93 (anticipated)

PRE-MEDICAL COURSES, UNIVERSITY OF MASSACHUSETTS
Amherst, Massachusetts
6/87 - 5/88

B.A., HAMPSHIRE COLLEGE
Amherst, Massachusetts
9/81 - 5/85
Concentration: Psychology and Physiology of Women
Thesis: Bulimia as a Heterogeneous Eating Disorder

RESEARCH EXPERIENCE

RECIPIENT, SUMMER RESEARCH FELLOWSHIP
University of Vermont Committee on Medical Research
6/90 - 9/90
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RESEARCH ASSISTANT
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CLINICAL EXPERIENCE

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President, UVM Medical Student Chapter, 1990 and 1991
Attended National Conference, 1990

American Medical Association

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

MT 032952 T

DANTZ RNEW

SONDRA BETH DANTZIC
MEDICAL COLLEGE OF PA
C/O JANET BESS
HOUSE STAFF OFFICE
3300 HENRY AVENUE
PHILADELPHIA, PA 19129

Present Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
07/01/94	06/30/95	2	OBG	HS-000140-L	MEDICAL COLLEGE OF PA

THIS IS YOUR RENEWAL NOTICE

1. **Renewal Training Period:**

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
7/1/95	6/30/96	3	OBGYN	HS-000140-L	Medical College of Pennsylvania

2. If you are not training in PA past ending date, check here. ___

3. Required Attachment: See #3B on instruction page.

Physician must answer all questions, sign and date form.

	Yes	No
4. Do you hold a license to practice medicine and surgery in any other jurisdiction? If yes, list each one.		X
5. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country?		X
6. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court.		X
7. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		X
8. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		X

[redacted]

7/1/95

00000035

GRADUATE LICENSE
RENEWAL INFORMATION AND INSTRUCTIONS

Your graduate license to participate in graduate medical training will expire on the ending date indicated on the renewal notice under "Present Training Period". You must renew your license if you are to continue training past the ending date. In order to renew, follow these instructions:

1. Indicate the correct information for the next training period in the space marked "Renewal Training Period" (1).

2. If you are not going to train past the ending date, check the "Not Training in PA past ending date" (2).

3. **REQUIRED ATTACHMENTS**

   A -- Attach a copy of your unrestricted license/registration card displaying expiration date **OR** copy of scores of FLEX 1; **OR** National Boards Part I and II; **OR** Part I of the National Boards or Step 1 of the USMLE **plus** Part II of the National Boards or Step 2 of the USMLE.

   B -- Attach a copy of your unrestricted license/registration card displaying expiration date **OR** copy of scores of FLEX 1 and 2; **OR** National Boards Part I, II and III; **OR** Part 1 of the National Boards or Step 1 of the USMLE **plus** Part II of the National Boards or Step 2 of the USMLE; **OR** USMLE **plus** Part III of the National Boards or Step 3 of the USMLE; **OR** Part 1 of the National Boards or Step 1 of the USMLE **plus** Part II of the National Boards or Step 2 of the USMLE **plus** FLEX 2; **OR** FLEX 1 **plus** Step 3 of the USMLE.

4. Answer questions 4-8 on the renewal notice. If you answer "YES" t questions 5-8, you must provide complete details on an additional sheet. If, after the Board has issued a license any of the events in questions 5,6,7, or 8 occur, you must report that matter to the Board in writing within 30 days after its occurrence.

5. Sign and date the form.

6. Attach a $10.00 fee made payable to the "Commonwealth of PA". Write your license number on your check. (The number is at the top of the notice). An individual fee is due for each renewal. Mail [illegible] address on top of the renewal notice.

NOTE -

A late penalty fee of $5.00 per month or part of a month is charged for renewals postmarked after the ending date.

A processing fee of $20.00 will be charged for any check or money order returned unpaid by your bank, regardless of the reason.

If, since your last renewal, you have experienced difficulties as a result of alcohol or other drugs such as diagnosis of/treatment for chemical dependency or abuse or arrests for chemical-use-related offenses, you may contact the Bureau's Professional Health Monitoring Program for confidential information and assistance at 1-800-564-[illegible].

RECEIVED

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Official Use Only 037659

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D A N T Z R N E W

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

SONDRA BETH DANTZIC
MEDICAL COLLEGE OF PA
C/O JANET BESS
HOUSE STAFF OFFICE
3300 HENRY AVENUE
PHILADELPHIA, PA 19129

Present Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
07/01/95	06/30/96	3	OBG	HS-000140-L	MEDICAL COLLEGE OF PA

THIS IS YOUR RENEWAL NOTICE

1. **Renewal Training Period:**

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
7/1/96	6/30/97	4	OBG	HS000140L	Med Col PA

2. If you are not training in PA past ending date, check here. ___

3. Required Attachment - See #3B on instruction page.

Physician must answer all questions, sign and date form.

	Yes	No
4. Do you hold a license to practice medicine and surgery in any other jurisdiction? If yes, list each one:	___	X
5. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country?	___	X
6. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court.	___	X
7. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?	___	X
8. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?	___	X

[redacted]
Signature

4/10/96
Date

00000139

Official Use Only 003641

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF STATE
BUREAU OF PROFESSIONAL AND
OCCUPATIONAL AFFAIRS
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PENNSYLVANIA 17105-2649
717-783-1400

MT-032952-T

DANTZ RNEW

SONDRA BETH DANTZIC
ALLEGHENY UNIV HOSPITALS-EAST FALLS
C/O JANET BESS
HOUSE STAFF OFFICE
3300 HENRY AVENUE
PHILADELPHIA, PA 19129

Present Training Period:

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name
07/01/96	06/30/97	4	OBG	HS-000140-L	ALLEGHENY UNIV HOSPITALS-EAST FALLS

THIS IS YOUR RENEWAL NOTICE

1. **Renewal Training Period:**

Beginning Date	Ending Date	Level	Specialty	Hospital License #	Hospital Name

2. If you are not training in PA past ending date, check here. ✓

3. Required Attachment - See #3B on instruction page.

Physician must answer all questions, sign and date form.

	Yes	No
4. Do you hold a license to practice medicine and surgery in any other jurisdiction? If yes, list each one:		✓
5. Since your last renewal, has any disciplinary action been taken against your license in another state, territory or country?		✓
6. Since your last renewal, have you been convicted, found guilty, or pleaded guilty or nolo contendere, or received probation without verdict as to any felony or misdemeanor, including any drug law violation, in any state or federal court.		✓
7. Since your last renewal, have you had practice privileges denied, revoked or restricted in a hospital or other health care facility?		✓
8. Since your last renewal, have you had your DEA registration denied, revoked or restricted or have you had your provider privileges terminated by any medical assistance agency for cause?		✓

[redacted]
Signature

1/23/97
Date

MAR 1997