STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PHYSICIAN/SURGEON APPLICATION FOR: $450.00

X Initial licensure ($450)

____ Reinstatement (Fee $450) CT License No.: _____ Date Granted: _____

PLEASE INDICATE (X) THE EXAMINATION(S) YOU COMPLETED:

X	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	Year Taken: I 1991 II 1992 III 1994		Licentiate of the Medical Council of Canada (LMCC)
	United States Medical Licensing Examination (USMLE) Was Step 3 taken in CT? If yes, what date _____		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

NAME: GARRETT (Last) Audrey (First) Paige (Middle) _____ (Maiden)

ADDRESS: 32 Francis St. (Street) Winthrop (Town) MA (State) 02152-2001 (Zip)

Please indicate below how you would like your name and address to appear on your official license. This will become your address of record for all future mailings.

NAME: AUDREY PAIGE GARRETT, MD

ADDRESS: 32 FRANCIS ST
WINTHROP MA 02152

Fax 401-277-3601

TELEPHONE NO.: (Where you may be reached 8:30-4:30, M-F) 401-453-7520

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: 11 / 10 / 64

MEDICAL EDUCATION:

List name and location of medical school(s) attended		Dates of Attendance
Columbia College of Physicians and Surgeons	New York, N.Y.	1989-1993

DEGREE AWARDED: MD MPH DATE AWARDED: 5/1993

MEDICAL LICENSURE:
List all states in which you have ever been licensed to practice medicine:

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY:	
			EXAM	ENDORSEMENT
MA	150737	1996		✓

SPECIALTY: If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of American Board:

AMERICAN BOARD OF: _____ Date Certified _____

MEDICAL PRACTICE:

List all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
Brigham and Womens Hospital	75 Francis St. Boston MA 02115	Internship 6/20/93-6/30/94
		Residency 7/1/94-6/30/97
		Fellowship 7/1/98-6/30/2001

STATEMENT OF PROFESSIONAL HISTORY

Please answer the following questions referring to the instructions, if applicable.

	YES	NO
1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: -Any hospital, nursing home, clinic, or similar institution; -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; -Any professional school, clinical clerkship, internship, externship, preceptorship or postgraduate training program;-Any third party reimbursement program, whether governmental or private?	___	✓
If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.		
2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?	___	✓
If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.		
3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?	___	✓
If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.		
4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?	___	✓
If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.		
5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit.	___	✓
If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.		

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? YES ___ NO ✓

If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.

7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state , federal law or the laws of another jurisdiction and which, if committed within this state, would have a felony under the laws of this state? ___ ✓

If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgment, the settlement, and/or the disposition of the case.

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded or fined by the responsible agency? ___ ✓

If your answer is "yes", give full details, dates, etc., on a separate notarized statement.

NOTARIZATION:

On this 23rd day of August (month) 2001 (year)

Audrey P Garrett (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached is a true picture of self and that the statements made herein are true in every respect.

Signature of Applicant: Audrey P Garrett MD

Signature of Notary Public: Mary S Jones *My commission expires* My Commission Expires December 18, 2003

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, "TREASURER, STATE OF CONNECTICUT" TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., MS# 12MQA
P.O. BOX 340308
HARTFORD, CT 06134-0308

IMPORTANT: The application packet for this profession consists of 11 pages, including instructions and eligibility requirements. Do not send this form and fee unless you have read and understood all pertinent information. No fees are refundable should you not be eligible for licensure.

NATIONAL BOARD OF MEDICAL EXAMINERS® (NBME®)
Endorsement of Certification

This document was prepared by
National Board of Medical Examiners® (NBME®)
3750 Market Street, Philadelphia, PA 19104-3190 - Telephone (215) 590-9592

Recipient: Connecticut Department of Public Health
Physician Licensure Department
PO Box 340308 MS #12 APP
410 Capitol Avenue
Hartford, CT 06134-0308

Date: 08/31/2001

Examinee: Audrey Paige Garrett

Examinee ID: 3-430-702-5
Date of Birth: 11/10/1964

NBME Certification Date: 07/01/1994

Certificate#: 430702

It is certified that the physician named above successfully completed the examination, education and training requirements for certification by the NBME as of the certification date shown above. This record shows only passing scores for each NBME Part examination reported on this document. If applicable, results for all USMLE Steps taken by this examinee (and for which scores have been reported to date) are also shown.

NBME PART I

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
06/11/1991	**Pass**	**Three-Digit**	208	(176)
		Two-Digit	84	(75)

USMLE STEP 2

		Three-Digit Scale		Two-Digit Scale		
Test Date	Pass/Fail	Total Score	(Min.Pass)	Total Score	(Min.Pass)	Comments
09/24/1992	**Pass**	212	(167)	84	(75)	

NBME PART III

Test Date	Pass/Fail	Score Scale	Total Score	(Min.Pass)
03/02/1994	**Pass**	**Three-Digit**	490	(315)
		Two-Digit	81	(75)

CT 1250

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: Audrey Paige GARRETT, M.D Date of Birth: 11/10/64

Dear Chief of Staff/Program Director:
Please provide the following verification of residency training for the above-named Connecticut physician/surgeon licensure applicant.

Name of facility where residency training was completed: Brigham and Women's Hospital

Dates of residency: From 6/20/1993 (month/day/year) To 6/30/1997 (month/day/year)

In what specialty was the residency training completed: OB/GyN

At what level(s) was this residency completed (PGY1, PGY2 etc.)? PGY 4

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? YES (YES or NO)

Did the applicant satisfactorily complete this period of residency training? Yes

Do you have any derogatory information regarding the competency or conduct of this applicant? No If yes, please attach any disclosable documents you may have on file regarding such information.

I, Robert L. Barbieri, M.D., being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: Brigham & Women's Hospital

Address: 75 Francis Street
Boston, MA 02115

Telephone Number: 617-732-4265

and that the information provided herein is true and correct to the best of my knowledge and belief.

Robert Barbieri
Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 30th day of August (month/ year) 2001

Linda Kuse
Notary Public's Signature

5/30/08
(My Commission Expires)

Please return this form directly to:
Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134-0308

MDAPP 10/99

Commonwealth of Massachusetts

Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111
(617) 727-3086
Fax (617) 451-9568

Date: 09/17/2001

To Whom It May Concern:

This is to certify **AUDREY P. GARRETT, M.D.,** a graduate of **Columbia Univ. College of Physicians & Surgeons** in the year **1993** , has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number **150737** was issued to Dr. GARRETT on May 1 1996. **THIS LICENSE IS CURRENT.** The expiration date is Nov 10 2001.

Our files contain no open complaint information on this physician.

Our files contain no closed complaint information on this physician.

Our files contain no disciplinary information on this physician.

SEAL

Peter Madras, M.D., Chairman

Please be advised that the above information is based entirely on examination of our open and closed complaint file. It is not based on a review of the application for licensure, renewal of licensure, or any reports that the Board is required to receive by statute (from courts, insurers, hospitals, etc...).

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DISCIPLINARY INQUIRY

APPLICANT: Please complete and sign this inquiry form and forward it to the Federation of State Medical Boards, at the address shown below.

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

The Connecticut Department of Public Health requests a disciplinary search concerning the following individual:

Garrett	Audrey	Paige	M.D
LAST NAME	FIRST NAME	MI	DEGREE

32 Francis St
STREET ADDRESS

Winthrop	MA	02152
CITY	STATE	ZIP

64/11/10
DATE OF BIRTH (YEAR/MONTH/DAY)

SOCIAL SECURITY NUMBER

622 W 168 St
Columbia College of Physicians and Surgeons New York, N.Y 10032
MEDICAL SCHOOL OF GRADUATION (Include complete name and branch location)

5/1993 USA
DATE OF GRADUATION COUNTRY OF MEDICAL SCHOOL

ECFMG NUMBER (if foreign medical graduate)

Audrey P. Garrett, MD 9/22/01
APPLICANT SIGNATURE

Please mail the response directly to:

Department of Public Health
Physician Licensure
410 Capitol Ave., MS# 12 APP
P.O. Box 340308
Hartford, CT 06134-0308

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

SEP 19 2001

Dale L. Austin
DALE L. AUSTIN
INTERIM CHIEF OPERATING OFFICER

Practitioner Profile for AUDREY P GARRETT, 1.039909 view pub update online

Practitioner Profile Status

Prepublication Status	None
Publication Status	Published
Pending Updates	NO

1. Physician Information update

License Number	39909
Effective Date	09/28/2001
Expiration Date	11/30/2002
Currently practicing medicine in CT	NO
Actively involved in patient care	NO

Practice Locations add

	Practice	Address	Languages	Primary?
update	Program in Women's Oncology	Women & Infants Hospital 101 Dudley Street Providence, RI 02905	Chinese Chinese Portuguese Spanish Spanish	YES
update	New England Medical Center	750 Washington Street Boston, MA 02111	Chinese Chinese Portuguese Spanish Spanish	NO

Staff Privileges add

Facility	Address	Start Date	End Date

2. Medical School update

Medical School	Columbia University College of Physicians and Surgeons
Year of Graduation	1993

3. Post Graduate Training add

	Start	End	Type	Level	Hospital	Address
update	07/01/1998	06/30/2001	GYN Oncology	Fellowship	Brigham & Women's Hospital	Boston, MA UNITED STATES
update	07/01/1994	07/01/1997	OB/GYN	Resident	Brigham & Women's Hospital	Boston, MA UNITED STATES
update	06/20/1993	07/01/1994	OB/GYN	Intern	Brigham & Women's Hospital	Boston, MA UNITED STATES

4. Specialty Area and Board Certification add

Specialty/Subspecialty	Board Cert Date	Speciality End Date	Certifying Board

5. CT Medical Education Responsibility update

Member of faculty of a CT medical school	NO
Medical School	
Current Responsibility for graduate medical education	YES

6. Publications, Professional Services, Activities, Awards add

	Publisher/Issuer	Title/Award Name	Date
update	ASCCP. 2000	George C. Trombetta Teaching Award	

7. Hospital Discipline add

Hospital	Address	Date	Discipline

8. Medical Malpractice Payments add dispute

Payment Date	Payment Category	Amount Paid	Related Practice Specialty

9. Felony Convictions add dispute

Date of Conviction	Conviction

10. CT Licensure Disciplinary Actions dispute

Date of Action	Action	License Status