

Application - Physician/Surgeon

Name	GABRIELA AURORA AGUILAR
Credential	Physician/Surgeon

Fee Details

Fee to Query NPDB	\$4.75
Initial Application Fee	\$565.00
	\$569.75

Past Connecticut Licensure/Certification

Please do not complete this application if you currently hold or have held a CT license/certificate for this profession.

This application is for individuals APPLYING for a license/certificate for the FIRST TIME. It is not for applicants who are attempting to renew a license/certificate or to reinstate a lapsed license/certificate.

If you are trying to renew a license/certificate and do not have your assigned user ID and password, please DO NOT CONTINUE with this application.

Please email oplc.dph@ct.gov and include, for your protection, your name, profession, date of birth and the last four digits of your Social Security number and your user ID and password will be emailed to you.

Please note that not all profession types allow for online renewal at this time.

To continue this application, select the 'Next' button at the bottom left corner of the screen.

Application Instructions

Thank you for applying for your license online. Please note that as part of this application, you will be required to upload a recent picture of yourself. Please make sure you have one available on the device you are using to file this application.

Please be advised that application fees submitted to the department are non-refundable.

Please note that you need to arrange for the submission, directly from the source, of a transcript from your medical school, verification of at least 2 years of progressive, post graduate residency training, verification of completion of the required examinations and verification of all licenses held, current or expired.

Applicants who completed medical school outside of the United States are required to arrange for their medical school to send a completed school verification form and a transcript directly to this office verifying completion of medical school. Non-US trained applicants are also required to arrange for the submission of verification of current certification by ECFMG.

For detailed information regarding eligibility and documentation requirements, please visit www.ct.gov/dph/license and select Physician/Surgeon.

As part of this application, you will provide information that will be used to create a profile that will be published on the Department's website. Following issuance of licensure, you will be provided with an opportunity to review and update the profile prior to its publication.

APPLICANTS WHO HAVE HELD A CT PHYSICIAN LICENSE IN THE PAST SHOULD NOT USE THIS SERVICE TO APPLY FOR REINSTATEMENT.

Demographic Information - Initial Application

1. Maiden Name
2. Please provide your Date of Birth
06/11/1987
3. U.S. Social Security Number

4. Gender
Female
5. Ethnicity: Please choose one
Hispanic or Latino
6. Race:
American Indian or Alaska Native
7. Please attach a recent photo of the applicant.
residency headshot.jpg

Basis of Licensure

Please select a basis for licensure.

Please note the following definitions:

Endorsement: Select this basis of licensure if you were educated in the United States and are, or have been, licensed in any other U.S. state or Canadian province.

Endorsement - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and you are, or have been, licensed in any U.S. state or Canadian province.

Exam: Select this basis of licensure if you were educated in the U.S. and this is the first time you are applying for a license in any jurisdiction.

Exam - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and this is the first time you are applying for a license in any jurisdiction.

8. Select Basis for Licensure
Endorsement

Federation Credentials Verification Service (FCVS)

FCVS obtains primary-source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the applicant's request, to any state medical and osteopathic board that has established an agreement with FCVS. Please note that this is optional.

9. If you plan to use the Federation Credentials Verification Service (FCVS) to verify your core credentials, enter your FCVS Packet ID here

Medical Education

10. Medical School
University of Illinois College of Medicine at Chicago
11. Year of Graduation
2015

Post Graduate Training Information

Please enter any internship, residency or fellowship training you have completed

12. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
University of Illinois at Chicago	Chicago	Illinois	UNITED STATES	06/24/2015	06/14/2019	Resident	OB/GYN

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

13. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at <https://npiregistry.cms.hhs.gov>.) If you do not have an NPI number, please enter ten (10) zeros):
1093101651

Specialty/Board Certification

Please enter your specialty, subspecialty and indicate the date on which you were certified by an ABMS ABMOS specialty board

14. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

Specialty	Subspecialty	Certifying Board	Certification Date
Obstetrics and Gynecology			

Other State License

15. Indicate states outside of CT where licenses are held, current or expired

State	Disciplinary Action
Illinois	No

Current Practice Information

16. Upon issuance of your Connecticut license, will you practice medicine in Connecticut?
Yes

17. Are you actively involved in patient care?
Yes

18. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
University of Illinois College of Medicine	820 S. Wood St.	M/C 808		Chicago	Illinois	60612	Yes	

Connecticut Hospitals and Nursing Home Privileges

Please enter the Connecticut hospitals and nursing homes where you will have admitting privileges

19. Indicate the Connecticut hospitals or nursing homes for which you have or will have staff privileges

Facility Name	City	State
Yale New Haven Hospital	New Haven	Connecticut

Medical Education Responsibilities

20. Are you a member of the faculty of a Connecticut medical school?
No

21. Select the state medical schools at which you are a member of the faculty.

22. Do you have current responsibility for graduate medical education?
No

Statement of Professional History

Please answer the following questions. If you answer yes to any of the questions regarding your professional history, please provide details in the space available below and arrange for the submission of supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review. Applicant's answering affirmatively to any question below may be contacted for additional information.

23. 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?

No

24. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?

No

25. 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?

No

26. 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?

No

27. 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?

No

28. 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?

No

29. 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 constituted a felony under the laws of this state?

No

30. Provide details regarding any question(s) above that you may have answered affirmatively.

Medical Malpractice Payment History

Please indicate below any malpractice payments that you have made or have been made on your behalf during the ten (10) year period immediately preceding the date of this application

31. Indicate your malpractice insurance carrier:

32. Indicate the medical malpractice payments that have been made by you or on your behalf within the past ten years.

Resolved Date	Payment Category	Amount Paid	Specialty	Group Count	Payment Count
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Felony Conviction History

Please list any felony that you have been convicted of during the ten (10) year period immediately preceding the date of this application

33. Please enter any felony convictions within the previous ten years.

Conviction Date	Conviction
-----------------	------------

Hospital Discipline

Please list any disciplinary action taken against you by a hospital during the ten (10) year period immediately preceding the date of this application

34. Please enter any felony convictions within the previous ten years.

Conviction Date	Conviction
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Publications, Services or Awards

Please indicate any publications, services or awards (this section is voluntary)

35. In this section, you may add any publications, professional services, activities, and awards that you would think useful to viewers of your profile.

Publisher/Issuer	Title/Award Name	Date
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Application Attestation

36. By filing this application online on the date indicated below, I attest that I am the person referred to in this application and that the photograph attached hereto is a true picture of me and that the statements made herein are true in every respect.

12/31/2018

American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of ones own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships with Patients

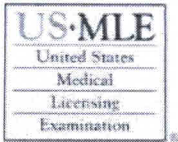
Romantic or sexual interactions between physicians and patients that occur concurrently with the patient-physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Review



United States Medical Licensing Examination® (USMLE®) Certified Transcript of Scores

This document was prepared by
Federation of State Medical Boards of the United States, Inc. (FSMB)
400 Fuller Wisser Road, Euless, TX 76039-3856 - Telephone (817) 868-4000

Recipient: CONNECTICUT MEDICAL EXAMINING BOARD

Date: 01/03/2019

Examinee: Aguilar, Gabriela Aurora
Alt Name(s):

Examinee ID: 5-303-501-0
Date of Birth: 06/11/1987

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

Test Date	Pass/Fail	Score	Minimum Pass	Comments
06/06/2013	Pass	218	(188)	

USMLE STEP 2

Clinical Knowledge (CK)

Test Date	Pass/Fail	Score	Minimum Pass	Comments
07/22/2014	Pass	244	(209)	

Clinical Skills (CS)

Test Date	Pass/Fail	Comments
10/10/2014	Pass	

USMLE STEP 3

Test Date	Pass/Fail	Score	Minimum Pass	Comments
05/03/2017	Pass	214	(196)	

End of Exam History

NOTE: A search of the Physician Data Center of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**

VERIFICATION OF RESIDENCY TRAINING FORM

Applicant: Enter your full name and birth date 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: Gabriela Aguilar Date of Birth: 06/11/1987

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

1. Name of facility where residency training was completed: University of Illinois at Chicago
2. Dates of participation: From 04/24/2015 To 04/23/2019
(month/day/year) (month/day/year)
3. In what specialty was the residency training completed: Obstetrics + Gynecology
4. At what level(s) was this residency completed (PGY1, PGY2, etc.): PGY1, PGY2, PGY3, PGY4
5. At the time of the individual's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA) or The Royal College of Physicians and Surgeons of Canada (RCPSC)? YES (YES or NO)
6. Did this individual satisfactorily complete this period of residency training? YES (YES or NO)*
7. Was this individual ever placed on probation? NO (YES or NO)*
8. Was this individual ever disciplined or placed under investigation? NO (YES or NO)*
9. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? NO (YES or NO)*

*If you answered "No" to question 6 or "Yes" to questions 7-9, please provide details and or attach any documents you may have on file regarding such information.

I, Abigail Litwiler MD, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: University of Illinois at Chicago

Address: 820 S Wood St, M/C 808
Chicago IL 60612

Telephone Number: (312) 996-0532 Email: ablitz1@uic.edu

I certify that the information above is an accurate account of the individual's record and is true and correct.

 1/7/19
Signature of Chief of Staff/Program Director Date

Please return this form directly to:

Connecticut Department of Public Health
Physician Licensure
410 Capitol Ave, MS#12APP
P.O. Box 340308
Hartford, CT 06134-0308
Fax: (860) 707-1931



Illinois Department of Financial
and Professional Regulation

Lookup Detail View

Contact

Contact Information

Name	City/State/Zip	DBA
GABRIELA AURORA AGUILAR MD	Chicago, IL 60612	

License

License Information

License Number	Description	Status	First Issuance Date	Effective Date	Expiration Date	Program	Program Start Date	Ever Disciplined
125066736	TEMPORARY MEDICAL PERMIT	EXPIRED	06/24/2015	06/24/2018	06/23/2019	Obstetrics and Gynecology	06/24/2018	N

Generated on: 12/4/2019 10:03:20 AM

Renewal - 1.062303

Name	GABRIELA AURORA AGUILAR
Credential	1.062303

Fee Details

Renewal Application Fee	\$575.00
	\$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at <https://npiregistry.cms.hhs.gov/>. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
06/11/1987
2. Gender
Female
3. Ethnicity: Please choose one
Hispanic or Latino
4. Race:
American Indian or Alaska Native

Address

5. Please update any changes to your mailing address:

Address 1: 1814 W NORTH AVE UNIT 302

Address 2:

City: CHICAGO

State: IL

Zip Code: 60622-2273

Country: UNITED STATES

6. Please update any changes to your primary address:

Address 1: 40 Temple Street

Address 2: Suite 3C

City: New Haven

State: CT

Zip Code: 06510

Country: UNITED STATES

Telephone Number: (203) 737-4665

Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplcdph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

- 7. Street Address
1814 W. North Ave.
- 8. Unit/Apartment Number
Unit 302
- 9. City
Chicago
- 10. State (two letter abbreviation)
IL
- 11. Zip Code
60622

Medical Education

- 12. Medical School
University of Illinois College of Medicine at Chicago
- 13. Year of Graduation
2015

Specialty/Board Certification

14. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

Specialty	Subspecialty	Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	

Current Workforce Status in Medicine

- 15. What is your current work status in medicine?
Full Time - (40 hours or more per week)
- 16. In the next 12 months, do you plan to (please mark all that apply):
None
- 17. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
Educator/Faculty
- 18. If your response to the previous question was other, please enter additional comments here.

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued

identifier to be used in transactions with all health plans with which the provider conducts business.

19. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at <https://npiregistry.cms.hhs.gov>.) If you do not have an NPI number, please enter ten (10) zeros):
1093101651

Professional Liability Insurance

Your professional practice act requires that a practitioner providing direct patient care services must maintain professional liability insurance or other indemnity against liability for professional malpractice. You may find information regarding professional liability insurance requirements by selecting this [link](#) and choosing your profession from the list.

Physician Renewal Practice Location

20. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Yale Department of Obstetrics, Gynecology, and Reproductive Sciences	PO Box 208063			New Haven	Connecticut	06520	Yes	

21. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?

3

22. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?

No

23. Please select the best choice for the type of ownership of your practice.

Hospital

Practice Ownership - Organization

24. Please enter the name of the organization/person that owns the practice where you work.

Yale Medicine

25. City

New Haven

26. State (two letter abbreviation)

CT

New Patients

27. Please select the best response that describes your patient care practice status:

I can accept some new patients; my practice is far from full

28. Are you accepting new patients covered by:

Both

Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

29. Medicare

less than 10%

30. Medicaid
51 - 75%
31. Self-Pay
less than 10%
32. Private Insurance
11 - 25%
33. Other
less than 10%
34. Does your practice offer sliding fee scale based on ability to pay?
No
35. Approximately what percentage of your patients use sliding fee schedules?
None

Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

36. Homeless
Less than 10%
37. Migrant/Seasonal Farm Workers
None
38. Native Americans
None

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

39. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
04/15/2019

Physician Attestation

40. Since your last renewal, have you been convicted of a felony?
No
41. If yes, please provide details here
42. Since your last renewal, have you had any disciplinary action taken against you or any such actions pending by any State, federal government jurisdiction, District of Columbia, United States possession or territory or foreign jurisdictions licensing/certification authority?
No
43. If yes, please provide details here

44. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.

Yes

45. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.

04/15/2019

American Medical Association's Opinions

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AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

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When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

- (a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.
- (b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

- (c) Document treatment or care provided and convey relevant information to the patient's primary care physician.
- (d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.
- (e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.
- (f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships with Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Important Note

To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select "**Pay Invoice**".

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.

Review
