STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

February 18, 2020

MONICA VIRGINIA DRAGOMAN, MD
30 Stratford Green Drive
Unit 2
Canfield, OH 44406

TO WHOM IT MAY CONCERN:

LICENSURE VERIFICATION

Please be advised that Connecticut General Statutes, certain matters involving the investigation and rehabilitation of Physician/Surgeon remain confidential. Therefore, in response to your inquiry regarding the status of the Physician/Surgeon identified below, at this time we are providing only publically disclosable information. In order for this office to confirm or deny whether there is any confidential information relevant to your inquiry, a release form from such Physician/Surgeon must be provided.

IF YOU WISH TO ESTABLISH WHETHER CONFIDENTIAL INFORMATION EXISTS CONCERNING THIS Physician/Surgeon, PLEASE HAVE HIM/HER SIGN THE REVERSE SIDE OF THIS FORM, WHICH CONSTITUTES A RELEASE FOR SUCH INFORMATION, AND RETURN IT TO THIS OFFICE. PLEASE NOTE THAT ONLY THIS DEPARTMENT'S RELEASE FORM WILL BE ACCEPTED.

This is to certify that the records of the Connecticut Department of Public Health indicate that:

MONICA VIRGINIA DRAGOMAN

Was issued Connecticut:	Physician/Surgeon License
Date of Issuance:	09/16/2016
License Number:	55728
Expiration Date:	09/30/2017
Status of License:	INACTIVE, LAPSED DUE TO NON-RENEWAL
Past or Pending Disciplinary History:	No

Sincerely,

Stephen B. Carragher

Stephen B. Carragher
Public Health Services Manager
Practitioner Licensing and Investigation Section

Printed by: Celeste Dowdell

Phone: (860) 509-7603
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12 APP
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

Application - Physician/Surgeon

Name	MONICA VIRGINIA DRAGOMAN
Credential	Physician/Surgeon

Fee Details

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

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 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 App

7. Maiden Name
   N/A

1. Please provide your Date of Birth
   09/22/1975

2. U.S. Social Security Number
   280-84-2112

3. Gender
   Female

4. Race:
   White

5. Ethnicity: Please choose one
   Not Hispanic or Latino

6. Please attach a recent photo of the applicant.
   Untitled.pdf

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
    Medical College of Ohio / The University of Toledo

11. Year of Graduation
    2002

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 Texas Southwestern Medical Center	Dallas	Texas	UNITED STATES	07/01/2002	06/30/2006	Resident	OB/GYN
Columbia University Medical Center	New York	New York	UNITED STATES	07/01/2006	06/30/2008	Fellowship	OB/GYN

Specialty/Board Certification

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

13. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	11/06/2009

Other State License

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

State	Disciplinary Action
New York	No

Current Practice Information

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

16. Are you actively involved in patient care?
Yes

17. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Planned Parenthood	26 Bleecker St	Ste 801		New York	New York	10012	Yes	

Connecticut Hospitals and Nursing Home Privileges

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

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

Facility Name	City	State

Medical Education Responsibilities

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

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

19. 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.

22. 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

23. 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

24. 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

29. 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

25. 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

26. 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

27. 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

28. 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

30. Indicate your malpractice insurance carrier:

31. 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

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

32. 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

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

Conviction Date	Conviction

Publications, Services or Awards

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

34. 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

Application Attestation

35. 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.

06/10/2016

Review

Profile - 1.055728

This profile contains information that may be used as a starting point in evaluating a health care provider. This profile should not, however, be the sole basis for selecting a health care provider. Please direct questions and comments about this profile to: Connecticut Department of Public Health, Physician Profiles, 410 Capitol Ave., M.S. 12 APP, P.O. Box 340308, Hartford, CT 06134-0308, oplc.dph@ct.gov.

Name	MONICA VIRGINIA DRAGOMAN
Credential	1.055728

Current Practice Locations

1. Are you currently practicing your licensed profession in Connecticut?
   Yes

2. Are you actively involved in patient care?
   Yes

3. Enter your practice locations

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Planned Parenthood	26 Bleecker St	Ste 801		New York	New York	10012	Yes	

Medical School

5. Medical School
   Medical College of Ohio / The University of Toledo

6. Year of Graduation
   2002

Post Graduate Training

7. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Columbia University Medical Center	New York	New York	UNITED STATES	07/01/2006	06/30/2008	Fellowship	OB/GYN
University of Texas Southwestern Medical Center	Dallas	Texas	UNITED STATES	07/01/2002	06/30/2006	Resident	OB/GYN

Specialty Area/American Board Certification

8. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	11/06/2009

Medical Education Responsibilities

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

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

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

Medical Malpractice Information

13. Indicate your malpractice insurance carrier:

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

Some studies have shown that there is no significant correlation between malpractice history and a physician's competence. At the same time, consumers should have access to malpractice information. This profile contains information about the malpractice payment history of the physician. Payment amounts have been placed into three statistical categories: below average, average and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- *Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares physicians only to the members of their specialty, not all physicians, in order to make an individual physician's history more meaningful.*
- *This malpractice information reflects data for the last 10 years of the physician's practice. For physicians practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.*
- *The incident causing the malpractice claim may have happened years before payment is finally made. Sometimes it takes a long time for a malpractice lawsuit to move through the legal system.*
- *Some physicians work primarily with high-risk patients. These physicians may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk of problems.*
- *Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred. For example, an insurer may choose to settle a case even if the physician opposes such settlement.*

You may wish to discuss the information provided in this report, and malpractice generally, with your physician.

Payments made by or on behalf of this healthcare provider:

Resolved Date	Payment Category	Specialty

Connecticut Hospital Discipline

This section contains categories disciplinary actions taken by hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

16. Please enter any disciplinary actions taken against you by any hospital within the previous 10 years.

Hospital Name	City	State	Country	Discipline Date	Disciplinary Action

Other State License

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

State	Disciplinary Action
New York	No

Profile Attestation

I hereby certify that to the best of my knowledge, the information contained in this profile is true and accurate and understand that providing false information may be grounds for sanction, which may include suspension revocation of my license to practice my profession in Connecticut.

21. Attestation Date

License Fee Information for 1.055728, MONICA VIRGINIA DRAGOMAN

Status: **INACTIVE** fee details

Fee Transactions Show All Re-Display Journal

Receipt	Date	Type	Amount	Short/Over	FROM	TO	Use / Reference
4760873	06/10/2016	Credit Summary	$569.75				
		Balance Due	**$0.00**				