Renewal - 1.050689

Name	MARILYN A. HAJAR
Credential	1.050689

Fee Details

Renewal Application Fee	$570.00
	$570.00

Demographic Information-Renewal

1. First Name
   MARILYN

2. Middle Initial
   A.

3. Last Name
   HAJAR

4. Maiden Name

5. Please provide your Date of Birth.
   11/02/1951

6. Gender
   Female

7. Ethnicity: Please choose one:
   Not Hispanic or Latino

8. Race:
   White

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

The purpose of the next several questions is to allow the Department of Public Health to collect valuable workforce data that is currently unavailable but critical in identifying and addressing healthcare workforce shortage issues.

Thank you for assisting the Department in this important initiative.

Current Workforce Status in Medicine

9. What is your current work status in Medicine?
   Part-time (less than 30 hours per week)

Workforce Survey

10. In the next 12 months, do you plan to (please mark all that apply):

11. If you are **NOT** working in your licensed profession, please indicate your plans for returning to work in your licensed field.

12. Please provide the number of hours per week that you provide DIRECT PATIENT CARE in your primary professional position.

If you do not provide hours in this category, please indicate 0.
7

13. Please provide the number of hours per week that you work as an ADMINISTRATOR/MANAGER in your primary professional position.

If you do not provide hours in this category, please indicate 0.
14

14. Please provide the number of hours per week that you work as an EDUCATOR/FACULTY in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

15. Please provide the number of hours per week that you work as a RESEARCHER in your primary professional position. If you do not provide hours in this category, please indicate 0.
0

16. If your primary profesional position is in a category other than those above, please provide that category in the box below and indicate the number of hours per week.

If you do not provide hours in this category, please indicate 0.
0

17. Please indicate the setting of your primary professional employment.

Enter comments if "Other" is selected.
Outpatient Clinic

Practice Location

If you are providing direct patient care, please identify the location of the primary site where you spend the most time providing direct patient care.

18. Address 1
3550 Main Street,

19. Address 2
Suite 201

20. City
Springfield

21. State
Massachusetts

22. Zip Code
01107

Primary Source of Payment

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

23. Medicare
less than 10%

24. Medicaid
26 - 50%

25. Self-Pay
less than 10%

26. Private Insurance
11 - 25%

27. Other
less than 10%

Attestation

28. Within the last year, have you been convicted of a felony?
No

29. If yes, please provide details here

30. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

31. If yes, please provide details here

By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license.

32. 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.
11/07/2014

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

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.

Please note that you will receive your new licensing documents (2 wallet-sized cards and 1 suitable for posting) during the third week of next month.

Thank you for processing your renewal online.

Review