STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN APPLICATION

☒ Initial licensure: ☒ MD ☐ DO ☐ Reinstatement CT License #: ______ Date Granted: ______

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

X	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	State Board Licensing Exam ______ (State) Year Taken: ______		Licentiate of the Medical Council of Canada (LMCC)
	United States Medical Licensing Examination (USMLE)		Combination of Segments (please specify)
	National Board of Osteopathic Examiners (NBOME)		

Do you plan to use the Federation Credentials Verification Service (FCVS) to verify your credentials? Yes ☒ Packet ID# 206686 No ☐

First Name: MARILYN **MI:** A **Last Name:** HAJAR **Maiden Name:** ______

US Social Security #: ___-___-____ **E-mail:** marilyn.hajar@gmail.com

Name and Mailing Address: This will be how your name and address will appear on your official license, your address of record for all mailings from this office and releasable pursuant to Freedom of Information requests.

Name on License: MARILYN A. HAJAR
Address: 1984 BROOK VIEW RD

City, State, Zip: CASTLETON, NY 12033

Phone Number: (518) 732-4214 **Date of Birth:** 11 / 02 / 1951 (Month / Day / Year) **Gender:** F

***RACE/ETHNIC DATA*:** (This section is voluntary. Information gathered will be used solely for the purpose of examining the demographics of Connecticut licensees. This data will not be used for discriminatory purposes and will not be considered in the evaluation of your application.)

☐ AMERICAN INDIAN OR ALASKAN NATIVE: Persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ ASIAN OR PACIFIC ISLANDER: Persons having origins in any of the original peoples of the Far East, Southeast Asia the Indian Subcontinent of the Pacific Islands. This area includes, for example, China, Japan, Korea, the Philippine Islands, and Samoa.

☐ BLACK: Persons having origins in any of the black racial groups of Africa.

☐ HISPANIC: Persons of Mexican, Puerto Rican, Central or South American or other Spanish culture or origin, regardless of race.

☒ WHITE (not of Hispanic Origin): Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

***LICENSURE*:** List *all* states in which you have ever been licensed to practice medicine (attach additional sheets as necessary):

State	License Number	State	License Number	State	License Number	State	License Number
NY	163110						
MA	151889						

Upon issuance of your license, will you practice medicine in Connecticut? ☐ Yes ☒ No look for work first

Will you be actively involved in patient care? ☐ Yes ☒ No

Please indicate the name of your malpractice insurance carrier: ______

CONNECTICUT PRACTICE INFORMATION N/A

Please indicate the name and location of the primary location where you will be practicing medicine in Connecticut:

Primary Practice Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip Code: ____________

Please list the languages, other than English, that are spoken at this location:

Second Practice Name: ______________________

Address: ______________________

City: ____________ State: ________ Zip Code: ____________

Please list the languages, other than English, that are spoken at this location:

Please list the Connecticut Hospitals or Nursing Homes where you will have admitting privileges:

EDUCATION

Please list the school you graduated from and the year the MD/DO degree was awarded:

Medical/Osteopathic School Name and Location/Country	Year of Graduation
ALBANY MEDICAL COLLEGE, ALBANY, NY	1984

POST-GRADUATE EDUCATION

Please list the following information regarding all of your post-graduate training (attach additional sheets if necessary):

Site, City and State	Date Start	Date End	Level (Intern, Resident, Fellow)	Training Type (Pediatrics, OB/GYN, etc)
ALBANY MEDICAL CENTER				
ALBANY, NY	7/1/1986	6/30/1990	RESIDENT	PATHOLOGY
ALBANY MEDICA CENTER				
ALBANY, NY	7/1/1984	6/30/1985	INTERN	OB/GYN

SPECIALTY & AMERICAN BOARD CERTIFICATION

Please indicate your practice specialty area:

Practice Specialty: GYNECOLOGY Practice Sub-Specialty: FAMILY PLANNING

Practice Specialty: PATHOLOGY Practice Sub-Specialty: CLINICAL PATHOLOGY

Please list current certifications held by the American Board of Medical Specialties (ABMS) or the American Board of Osteopathic Medical Specialties

American Board of: PATHOLOGY Date Certified: 6 / 4 / 1992

American Board of: ______ Date Certified: ___/___/___

PUBLICATIONS, PROFESSIONAL SERVICES, ACTIVITIES/ AWARDS (THIS SECTION IS VOLUNTARY)

Please include a maximum of ten (10) entries in this section. For publications, please attach a CV with selected entries highlighted or a typed list.

Publication/Entity Issuing Award	Title of Article/Award	Date Published/Awarded

MEDICAL EDUCATIONAL RESPONSIBILITIES

Are you/will you be a member of the faculty of a Connecticut medical school? ☐ Yes ☒ No

If Yes, Please indicate which one. ☐ Yale University Medical School ☐ University of Connecticut School of Medicine

Do you/will you have current responsibility for graduate medical education in Connecticut? ☐ Yes ☒ No

HOSPITAL DISCIPLINE

Please list any revocation or restriction of hospital privileges for reasons related to competence or quality of patient care that has been taken by the hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also include the resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course of an investigation. Please list only those that have occurred within the most recent ten (10) years. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Hospital, City and State	Date	Disciplinary Action

MEDICAL MALPRACTICE PAYMENTS

Please list medical malpractice court judgments and all medical malpractice arbitration awards in which a payment was awarded to a complaining party in the last ten (10) years in any state that you have held an active license. Also list all settlements of malpractice claims in which a payment was made to a complaining third party in the last ten years in any state in which you have held an active license. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Date Resolved	Amount Paid	Practice Specialty Related To Payment

FELONY CONVICTIONS

Please list any felony convictions in any state within the last ten (10) years. For the purpose of this section a person shall be deemed to be convicted of a crime if the licensee plead guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere in any state. If you require additional space please provide details on a separate sheet of paper indicating the section for which you are providing additional information.

Date of Conviction	Conviction

STATEMENT OF PROFESSIONAL HISTORY*: Please answer the following questions referring to the instructions, if applicable.*

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? Yes ☐ No ☒
   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? Yes ☐ No ☒
   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? Yes ☐ No ☒
   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? Yes ☐ No ☒
   If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.

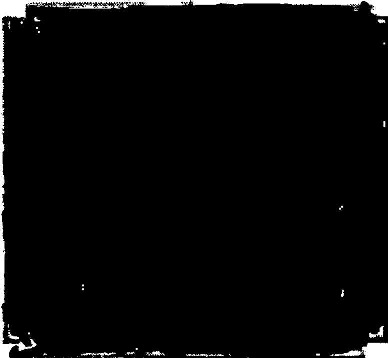
5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. Yes ☐ No ☒
   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?
   If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement. Yes ☐ No ☒

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. Yes ☐ No ☒

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. Yes ☐ No ☒

On this 30 day of JANUARY/2012 *(month/year)* MARILYN HAJAR *(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 hereto is a true picture of self and that the statements made herein are true in every respect.



All of the above statements contained herein are true and correct to the best of my knowledge and belief.

Marilyn A. Hajar

SIGNATURE OF APPLICANT

Sworn to me this 30 day of JANUARY (month/year) 2012

Notary Public Signature ____________ My Commission Expires ____________

Please return this application, the fee for $565.00 (certified bank check or money order) *and* a separate certified bank check or money order for $4.75 made payable to, "Treasurer, State of Connecticut" to:

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

***IMPORTANT:* Please do not send this form and fee unless you have read and understood the licensing policies and requirements. All fees are non-refundable.**