Renewal - 1.050689

Name	MARILYN A. HAJAR
Credential	1.050689

Fee Details

Fee Increase Effective 7/12/13	$5.00
Renewal Application Fee	$565.00
	$570.00

Demographic Information

1. First Name
   MARILYN

2. Middle Initial
   A

3. Last Name
   HAJAR

4. Personal Suffix

5. Maiden Name

6. Social Security Number
   017426423

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

8. Gender
   Female

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

10. 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

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

Workforce Survey

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

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

14. 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.
14

15. 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.
7

16. 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

17. 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

18. 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.

Comments: None of these hours are provided in the state of Connecticut.

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

Enter comments if "Other" is selected.
Outpatient Clinic

20. Gender
Female

21. Race:
White

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

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.

23. Address 1
136 Lake Street

24. Address 2

25. City
Newburgh

26. State
New York

27. Zip Code
12550

Primary Source of Payment

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

28. Medicare
None

29. Medicaid
11 - 25%

30. Self-Pay
26 - 50%

31. Private Insurance
11 - 25%

32. Other
less than 10%

Attestation

33. Have you been convicted of a felony since your last application?
No

34. Have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority since your last application?
No

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.

Important Note

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.

To continue processing your renewal, please click "Next" below.

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

On the top right of the invoice screen, you will be given the option to **"Pay Invoice"** or **"Print Invoice."** When you are ready to pay the renewal fee due, choose **"Pay Invoice"** to process your credit card payment.

Thank you for processing your renewal online.

Review