OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
Board of Medicine
121 South Fruit Street, Suite 301
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director

RT – 3177

This is to certify that **Kanthi Dhaduvai, M.D.**, has been granted a TRAINING LICENSE to practice as a Medical Resident at Concord Feminist Health Center, Concord, NH, or off-site, under faculty supervision, as determined by the facility, as part of their training program.

Service begins 08/18/17 and ends 06/30/18.

Karen Carney for
Penny Taylor
Administrator

Date Issued: July 27, 2017

(Seal)

This certificate does not entitle holder to practice after the specified date.

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PETER DANLES
Executive Director

JOSEPH G. SHOEMAKER
Division Director

July 27, 2017

Dear Dr. Dhaduvai:

You have been issued a Resident license to practice medicine in New Hampshire at the facility or facilities indicated on the license, which has been sent directly to the facility or facilities. As a licensee in New Hampshire, you are required to register for the NH Prescription Drug Monitoring Program ("NH PDMP"). (Med 501.02(l)). Please visit the website at www.newhampshirepdmp.com and register using the attached instructions. ***If you require assistance with this process, please contact Health Information Designs (HID) helpdesk at 855-353-9903 or nhpdmp-info@hidinc.com.*** HID is the vendor for New Hampshire's PDMP.

PLEASE NOTE: Pursuant to New Hampshire law RSA 318-B:36, III, "any person who engages in prescribing or dispensing of controlled substances in schedule II-IV without having registered with the program may be subject to discipline by the appropriate regulatory board."

If you fail to register as required, or if you prescribe or dispense a schedule II-IV substance prior to registering, the NH Board of Medicine will be notified. Please feel free to contact me at 271-1205 or penny.taylor@nh.gov with any questions or concerns.

Thank you for taking the time to enroll in this important program. If you have any suggestions on how we can improve the program, please let me know.

Sincerely,

Penny Taylor, Administrator
Board of Medicine

\pt

Enclosure

Online Registration – ACCESS the DATA
New Hampshire Prescription Drug Monitoring Program

The New Hampshire Prescription Drug Monitoring Program (PDMP) grants system access accounts to practitioners and approved delegates so that they may look up, and view, controlled substance dispensing information on specific patients .

Practitioners can perform the following steps to request an account:

1. Open an Internet browser window and navigate to the following URL: www.newhampshirepdmp.com

2. Click the Practitioner/Pharmacist link located on the left menu.

3. Click Registration Site → A login window is displayed.

4. Type **newacct** in the User Name field.
5. Type **welcome** in the Password field.
6. Click OK.

7. Complete the fields on this form, noting that "Master" should be selected in the **Account Type** field. Required fields are indicated with an asterisk (*). (Note: Pharmacist do NOT need a DEA # to register)

   Pharmacist please put (license#) – If you have an R before your license be sure to include this. **example: 1234 or R1234**

8. Click **Submit.**

If information is incomplete or missing, a message is displayed indicating which fields must be corrected before your account request form can be submitted.

PLEASE EMAIL THE REGISTRATION NUMBER TO Joanie.Foss@nh.gov TO ACTIVATE YOUR ACCOUNT!!!

If you are approved for an account, you will be notified via two separate e-mails. The first e-mail will contain your approval notification and user name information. The second e-mail will contain your temporary password, your personal identification number (PIN) that you will use to identify yourself if you need assistance from the HID Help Desk, and the steps to follow to log in to the system. You will be required to change the temporary password immediately when you first attempt to access the system.

NH PRESCRIPTION DRUG MONITORING PROGRAM

317

RECEIVED

JUN 16 2017

NH BOARD

STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520

APPLICATION FOR TRAINING LICENSE
RESIDENTS AND GRADUATE FELLOWS

Ch. 514163162 $150

FEE FOR TRAINING LICENSE IS **$50.00**. PLEASE MAKE CHECK PAYABLE TO: TREASURER, STATE OF NEW HAMPSHIRE.

****Please print legibly or type:**

NAME OF APPLICANT: DHADUVAI, KANTHI (Last) (First) (M) (Maiden) ☐ (Male) ☒ (Female)

CURRENT RESIDENCE ADDRESS: [redacted]

PHONE NUMBER [redacted]

BIRTH DATE [redacted] (Month Day Year) **BIRTH PLACE** [redacted] (City State Country)

SOCIAL SECURITY #: [redacted]

MEDICAL SCHOOL(S) New York Medical College

DATES ATTENDED 08/2011 – 05/2015 **YEAR M.D. RECEIVED** 2015

CURRENT TRAINING HOSPITAL CHA-Tufts

TRAINING PROGRAM Concord Feminist Health Center
Equality Health Center
38 S. main St
Concord, NH

BEGIN DATE (TRAINING) 8 | 18 | 17 (Month Day Year) **FINISH DATE** (TRAINING) 06 30 2018 (Month Day Year)

USMLE STEPS 1 AND 2 (PLEASE INDICATE DATES TAKEN AND PASSED)

STEP 1 June 2013 (Month Year) **STEP 2** June 2014 (CS) September 2014 (CK) (Month Year)

(Certification received directly from the National Board of Medical Examiners (NBME) that the applicant has taken and passed USMLE steps 1 and 2 is **required**.)
You must have this certification sent directly to the N.H. Board of Medicine.

STANDARD ECFMG Certificate Number (if applicable)

SUPPLEMENT TO APPLICATION FOR TRAINING LICENSE AS RESIDENT/FELLOW

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW:

		YES	NO
1.	Have you ever resigned from a medical education program or medical practice position?		✓
2.	Do you now or have you ever held a license in another state? If so, please complete the following:	✓	

STATE	TYPE (Training, Full, Temporary)
MA	Training

Original verification of all prior licenses is required (whether the license is a full, training or temporary license).

3.	Have you ever been reprimanded, sanctioned, restricted or disciplined in any activities involving medical education or practice?		✓
4.	Have you ever been convicted of a felony?		✓
5.	Are you now, or have you been in the past, dependent on alcohol or drugs?		✓

****If you answered yes to any of the above questions, please provide a complete description on the reverse side. You may attach additional sheets as necessary.**

I hereby certify, under penalty of perjury, that all of the information provided in this application is complete and accurate.

NAME (PLEASE PRINT) Kanthi Dhaduvai

SIGNATURE Kanthi Dhaduvai DATE 01/10/2017

VERIFICATION BY ACCREDITED PROGRAM

****

The above named applicant will be duly enrolled in the accredited residency or graduate fellowship program designated below, and the undersigned, an authorized agent of that program, hereby certifies that all of the above information concerning the applicant is correct.

Signature

RICHARD J RIES, MD
Director, Graduate Medical Education

1/18/17
Date

I, Greg Larson Sauer, have reviewed the personal and professional qualifications of the above named applicant and hereby certify that the applicant is approved for entry into _____ training program.

Signature

GREGORY SAUER MD MPH
Program Director

1/18/17
Date