Renewal - 1.039600

Name	ELIZABETH M KONTARINES
Credential	1.039600

Fee Details

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

Demographic Information

1. First Name
   ELIZABETH
2. Middle Initial
3. Last Name
   KONTARINES
4. Personal Suffix
5. Maiden Name
6. Please provide your Date of Birth.
   01/16/1968
7. Gender
   Female
8. Ethnicity: Please choose one:
   Not Hispanic or Latino
9. 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

10. What is your current work status in Medicine?
    Full Time - (30 hours or more per week)

Workforce Survey

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

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

13. 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.
50

14. 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.
3

15. 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.
24

16. 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

17. 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.

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

Enter comments if "Other" is selected.

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.

19. Address 1
27 Hospital Ave

20. Address 2

21. City
Danbury

22. State
CT

23. Zip Code
06488

Primary Source of Payment

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

24. Medicare
21 - 50%

25. Medicaid
26 - 50%

26. Self-Pay
less than 10%

27. Private Insurance
26 - 50%

28. Other
None

Attestation

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

30. If yes, please provide details here

31. 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

32. 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.

33. 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.
12/31/2013

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 (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".**

Thank you for processing your renewal online.

Review