$4.00

IL.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

PHYSICIAN/SURGEON APPLICATION FOR:

✓ Initial licensure ($450)

____ Reinstatement (Fee $450) CT License No.: _____ Date Granted: _____

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

	National Board of Medical Examiners (NBME)		Federation Licensing Examination (FLEX)
	Year Taken: _____		Licentiate of the Medical Council of Canada (LMCC)
X	United States Medical Licensing Examination (USMLE) Was Step 3 taken in CT? If yes, what date 5/98		Combination of Segments (please specify) -
	National Board of Osteopathic Examiners (NBOME)		

NAME: KONTARINES ELIZABETH MARIA
(Last) (First) (Middle) (Maiden)

ADDRESS: 301 HULLS HILL ED SOUTHBURY CT 06488
(Street) (Town) (State) (Zip)

Please indicate below how you would like your name and address to appear on your official license. This will become your address of record for all future mailings.

NAME: Elizabeth M. Kontarines.

ADDRESS: 301 HULLS HILL ED.
SOUTHBUEY, CT. 06488

TELEPHONE NO.: (Where you may be reached 8:30-4:30, M-F) (203) 267-0698

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: 01, 16, 68

MEDICAL EDUCATION:
List name and location of medical school(s) attended — Dates of Attendance

SAINT GEORGES UNIVERSITY 01/93 - 06/97
SCHOOL OF MEDICINE, GRENADA WEST INDIES

DEGREE AWARDED: M.D. DATE AWARDED: 6/97

MEDICAL LICENSURE:
List all states in which you have ever been licensed to practice medicine:

STATE	LIC. NUMBER	DATE ISSUED	LICENSED BY:	
			EXAM	ENDORSEMENT

SPECIALTY: If certified by a specialty board approved by the American Board of Medical Specialties (ABMS), indicate name of American Board:

AMERICAN BOARD OF: _____ Date Certified _____

MEDICAL PRACTICE:

List all medical practice you have engaged in since graduation from medical school (identify internship and residency):

Hospitals Associated With	Location	Dates
INTERNSHIP	DANBURY HOSPITAL - DANBURY, CT	6/97 - 6/98
RESIDENCY	DANBURY HOSPITAL - DANBURY, CT.	7/98 - 6/00
CHIEF RESIDENCY	DANBURY HOSPITAL - DANBURY, CT	7/00 - 6/01

STATEMENT OF PROFESSIONAL HISTORY

Please answer the following questions referring to the instructions, if applicable.

	YES	NO
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? **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? **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? **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? **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. **If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.**	___	✓

	YES	NO
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.		
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.		
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.		

NOTARIZATION:

On this 22 day of APRIL (month) 2001 (year)

Elizabeth Kontogiannes (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 is a true picture of self and that the statements made herein are true in every respect.

Signature of Applicant: E Kontogiannes

Signature of Notary Public: Doris Kollman *My commission expires*

DORIS KOLLMAN
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2005

PLEASE RETURN THIS APPLICATION AND THE FEE FOR $450 (CERTIFIED CHECK OR MONEY ORDER) MADE PAYABLE TO, "TREASURER, STATE OF CONNECTICUT" TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE., MS# 12MQA
P.O. BOX 340308
HARTFORD, CT 06134-0308

IMPORTANT: The application packet for this profession consists of 11 pages, including instructions and eligibility requirements. Do not send this form and fee unless you have read and understood all pertinent information. No fees are refundable should you not be eligible for licensure.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
SCHOOL VERIFICATION FORM

Applicant: Please complete Section 1 of this form and forward it to your medical school.

THIS FORM, IN ADDITION TO AN OFFICIAL TRANSCRIPT, NEED ONLY BE SUBMITTED IF THE APPLICANT EARNED A DEGREE OUTSIDE OF THE UNITED STATES OR CANADA

Section 1:

Name of Applicant: Elizabeth Kontarines

Date of Birth: 01/16/68 YEAR OF GRADUATION 6/97

Section 2: (This section to be completed by the medical school.)

This office has received an application for Connecticut physician licensure from the individual identified above. In order to complete our review of this individual's credentials for licensure, a verification of educational background is needed. The information below should be completed by the Dean, Registrar or other official authorized to verify educational records at the institution.

Name of Educational Institution: St George's University School of Medicine

Address of Educational Institution: P.O. Box 7 Grenada West Indies

Date of studies FROM: 01/18/93 TO: 05/02/97

Total number of months of full-time classroom and supervised clinical instruction (record in MONTHS only): not less than 39 months

Did this individual satisfactorily complete the full medical curriculum at this institution? YES: ✓ NO: ___

Was this individual granted a degree? YES: ✓ NO: ___ Title of Degree: MD

Date Awarded: May 16, 1997

At the time of this student's attendance, was this medical school fully licensed and approved, by the appropriate regulatory body of the jurisdiction in which it is located, to award the degree of doctor of medicine or its equivalent? YES: ✓ NO: ___

Signature — 4/25/2001 Date

Margaret A. Lambert
Dean of Enrolment Planning
Title

SEAL

PLEASE COMPLETE THIS FORM AND SEND IT DIRECTLY TO:

DEPARTMENT OF PUBLIC HEALTH
PHYSICIAN LICENSURE
410 CAPITOL AVE, MS #12 APP
P.O. BOX 340308
HARTFORD, CT 06134-0308

United States Medical Licensing Examination™ (USMLE™)
Certified Transcript of Scores

US·MLE
United States Medical Licensing Examination™

This Transcript was prepared by the Federation of State Medical Boards

Date of Certification: 05/02/2001

Connecticut Medical Examining Board
ATTN: Maritsa Morales, Office Assistant
Adjudications Office
P O Box 340308
Hartford, CT 06134-0308

Examinee: Kontarines, Elizabeth Maria
USMLE ID#: 0-537-053-1
DOB: 01 / 16 / 1968
Alt Name(s):

Results for all Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Scores are reported on two scales. The recommended minimum passing score ("Passing") on each scale is shown in parentheses.

STEP1	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	6/14/1995	PASS	202	(176)	82	(75)	

STEP2	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
	8/27/1996	PASS	216	(170)	85	(75)	

STEP3 State Board	Test Date	Pass/ Fail	Three-Digit Score	(Passing)	Two-Digit Score	(Passing)	Comments
CONNECTICUT	5/12/1998	PASS	199	(177)	81	(75)	

A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on the above-named examinee.

UNOFFICIAL COPY - NOT AN ORIGINAL DOCUMENT

Patent 5636874

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES
PHILADELPHIA OFFICE
3624 MARKET STREET, PHILADELPHIA, PENNSYLVANIA 19104-2685, U.S.A.
TELEPHONE: 215 386-5900 • FAX: 215 386-6327 • INTERNET: www.ecfmg.org

State Board Code:
007
Please include this number on all requests.

SECTION CHIEF
CONNECTICUT DEPT. OF PUBLIC HEALTH PHYSICIAN LIC.
410 CAPITOL AVE., MS# 12APP
P. O. BOX 340308
HARTFORD, CT 06134-0308

ECFMG CERTIFICATION STATUS REPORT

ECFMG/USMLE Identification Number: 0-537-053-1
Applicant's Name: Elizabeth Maria Kontarines
Applicant's Date of Birth: 01/16/1968
ECFMG Certified: Yes
Certificate Issue Date: 06/23/1997
English Test Valid-Through Date: Indefinitely
Passing Performance on Medical Science Examination for Certification:

Examination Type	Date	Component	Two-Digit Score	Three-Digit Score	Comments
STEP1	JUN 1995	BASIC SCIENCE	82	202	
STEP2	AUG 1996	CLINICAL SCIENCE	85	216	

Most Current Passing Performance on English Test: August 1996
Name of Medical School and Country: SAINT GEORGE'S UNIVERSITY, GRENADA
Degree Year: 1997
† Medical Education Credential Status: Complete and verified

This information is reported directly from ECFMG computer records and is current as of 27 April 2001.

† Since July 1986, ECFMG has verified medical school credentials directly with the medical schools or through a reasonable alternative which has been approved by the ECFMG Medical Education Credentials Committee.

Important Note:
Requesting organizations must normally secure and retain the physician's signed authorization to obtain certification information. Organizations may not resell the information or make it available to any party beyond the initial request as authorized by the physician. The information may only be used to confirm ECFMG certification for the purpose for which the physician provided authorization.

ECFMG℠ is an organization committed to promoting excellence in international medical education

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: Elizabeth Kontorines, MD Date of Birth: 01.16.68

Dear Chief of Staff/Program Director:
Please provide the following verification of residency training for the above-named Connecticut physician licensure applicant.

Name of Facility where residency training was completed: Danbury Hospital

Dates of residency: From July 1, 1997 (month/day/year) To June 30 2001 (month/day/year)

In what specialty was the residency training completed: Obstetrics & Gynecology

At what level(s) was this residency completed (PGY1, PGY2 etc.)? PGY IV

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? yes

Do you have any derogatory information regarding the competency or conduct of this applicant? No If yes, please attach any disclosable documents you may have on file regarding such information.

I, Sandra McGuire, being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at: Program Manager

Name of Facility: Danbury Hospital

Address: 24 Hospital Ave
Danbury CT 06810

Telephone Number: 203-797-7878

and that the information provided herein is true and correct to the best of my knowledge and belief.

Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 29 day of May ~~19~~ 2001

Notary Public's Signature

2/31/03
(My Commission Expires)

Please return this form directly to:
Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
VERIFICATION OF RESIDENCY TRAINING

APPLICANT: Enter your full name and birthdate on this form and forward it to the Chief of Staff or program director at the facility in which you completed your residency training. This form must be completed by the facility and returned directly to this office.

Applicant's name: Elizabeth M. Contarines Date of Birth: 01/16/68

Dear Chief of Staff/Program Director:
Please provide the following verification of residency training for the above-named Connecticut physician/surgeon licensure applicant.

Name of facility where residency training was completed: Danbury Hospital

Dates of residency: From 7/1/97 (month/day/year) To 6/30/01 (month/day/year)

In what specialty was the residency training completed: Obstetrics & Gynecology

At what level(s) was this residency completed (PGY1, PGY2 etc.)? PGY IV

At the time of the applicant's training, was the residency training program in this specialty area accredited by the Accreditation Council for Graduate Medical Education? yes (YES or NO)

Did the applicant satisfactorily complete this period of residency training? yes

Do you have any derogatory information regarding the competency or conduct of this applicant? No If yes, please attach any disclosable documents you may have on file regarding such information.

I, Sandra McGuire, Program Mgr., being duly sworn, do depose and certify that I am the Chief of Staff/Program Director at:

Name of Facility: Danbury Hospital

Address: Dept. of Ob/Gyn
24 Hospital Ave, Danbury, CT 06810

Telephone Number: (203) 797-7878

and that the information provided herein is true and correct to the best of my knowledge and belief.

Signature of Chief of Staff/Program Director

Subscribed and sworn to me this 23rd day of April (month/ year) 2001

Notary Public's Signature

7/31/03
(My Commission Expires)

Please return this form directly to: Department of Public Health
410 Capitol Ave., MS # 12 APP
Physician Licensure
P.O. Box 340308
Hartford, CT 06134-0308

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
DISCIPLINARY INQUIRY

APPLICANT: Please complete and sign this inquiry form and forward it to the Federation of State Medical Boards, at the address shown below.

Federation of State Medical Boards
400 Fuller Wiser Road
Euless, TX 76039

The Connecticut Department of Public Health requests a disciplinary search concerning the following individual:

KONTABINES	ELIZABETH	MARIA	M.D.
LAST NAME	FIRST NAME	MI	DEGREE

301 HULLS HILL RD		
STREET ADDRESS		
SOUTHBURY	CT	06488
CITY	STATE	ZIP

68 | 01 | 16
DATE OF BIRTH (YEAR/MONTH/DAY)

SOCIAL SECURITY NUMBER

MEDICAL SCHOOL OF GRADUATION (Include complete name and branch location)

6/97	GRENADA WEST INDIES
DATE OF GRADUATION	COUNTRY OF MEDICAL SCHOOL

0-537-053-1
ECFMG NUMBER (if foreign medical graduate)

E. Kontabines
APPLICANT SIGNATURE

Please mail the response directly to:

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

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN

APR 26 2001

DALE L. AUSTIN
INTERIM CHIEF OPERATING OFFICER

Practitioner Profile for ELIZABETH M KONTARINES, 1.039600 view pub update online

Practitioner Profile Status

Prepublication Status	None
Publication Status	Published
Pending Updates	YES

1. Physician Information update

License Number	39600
Effective Date	06/11/2001
Expiration Date	01/31/2020
Currently practicing medicine in CT	YES
Actively involved in patient care	NO

Practice Locations add

	Practice	Address	Languages	Primary?
update	Womens Health Associates	27 Hospital Ave Danbury, CT 06810		YES

Staff Privileges add

	Facility	Address	Start Date	End Date
update	WATERBURY HOSPITAL			

2. Medical School update

Medical School	St. Georges University School of Medicine
Year of Graduation	1997

3. Post Graduate Training add

	Start	End	Type	Level	Hospital	Address
update	06/18/1998	06/21/2001	OB/GYN	Resident	Danbury Hospital	Danbury, CT UNITED STATES
update	06/17/1997	06/17/1998	OB/GYN	Intern	Danbury Hospital	Danbury, CT UNITED STATES

4. Specialty Area and Board Certification add

	Specialty/Subspecialty	Board Cert Date	Speciality End Date	Certifying Board
update	Obstetrics and Gynecology add sub	01/07/2002		American Board of Obstetrics and Gynecology
update	Obstetrics and Gynecology add sub			

5. CT Medical Education Responsibility update

Member of faculty of a CT medical school	NO
Medical School	
Current Responsibility for graduate medical education	NO

6. Publications, Professional Services, Activities, Awards add

Publisher/Issuer	Title/Award Name	Date

7. Hospital Discipline add

Hospital	Address	Date	Discipline

8. Medical Malpractice Payments add dispute

Payment Date	Payment Category	Amount Paid	Related Practice Specialty

9. Felony Convictions add dispute

Date of Conviction	Conviction

10. CT Licensure Disciplinary Actions dispute

Date of Action	Action	License Status

Post Prepublication | Post Publication