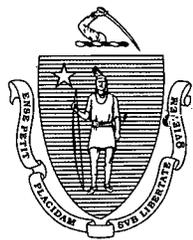


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146002 Ann



# Commonwealth of Massachusetts Board of Registration in Medicine

200 Harvard Mill Square, Suite 330  
Wakefield, Massachusetts 01880  
(781) 876-8200

[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

Enforcement Division Fax: (781) 876-8381  
Legal Division Fax: (781) 876-8380  
Licensing Division Fax: (781) 876-8383

CANDACE LAPIDUS SLOANE, MD  
Chair, Physician Member

GEORGE ABRAHAM, MD  
Vice Chair, Physician Member

JULIAN N. ROBINSON, MD  
Secretary, Physician Member

WOODY GIESSMANN, LADC-I, CADAC, CIP, CAI  
Public Member

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Secretary  
Health and Human Services

MONICA BHAREL, MD, MPH  
Commissioner  
Department of Public Health

ORIGINAL

11/13/2019

To Whom It May Concern:

This certifies that Maureen E Paul, M.D., a 1979 graduate of Tufts University School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 48979 was issued to Dr. Paul on 03/02/1982. The license status is: Active. The expiration date is 9/19/2020.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

MEDICINE BOARD  
2019 NOV 19 AM 12:23

**Closed Complaint Information**

Our files contain 0 closed complaint(s) on this physician.

**Final Board Disciplinary Action**

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

[www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

Staff Member, Board of Registration in Medicine

Tammi McManus

SEAL

AC#

**COPY**

STATE OF FLORIDA  
DEPARTMENT OF HEALTH  
DIVISION OF MEDICAL QUALITY ASSURANCE

DATE	LICENSE NO.	CONTROL NO.
02/12/2020	ME 144132	709082

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **JANUARY 31, 2022**  
MAUREEN ELIZABETH PAUL  
BETH ISRAEL DEACONESS MEDICAL CENTER  
DEPT. OB-GYN  
330 BROOKLINE AVENUE, KS-3  
BOSTON, MA - 02215

**COPY COPY COPY**

STATE OF FLORIDA DEPARTMENT OF HEALTH DIVISION OF MEDICAL QUALITY ASSURANCE	AC#	LICENSE NO.	CONTROL NO.
DATE	02/12/2020	ME 144132	709082

THE MEDICAL DOCTOR

NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date: **JANUARY 31, 2022**  
MAUREEN ELIZABETH PAUL

COPY - NOT A VALID LICENSE - COPY  
LICENSEE SIGNATURE

**COPY - NOT A VALID LICENSE - COPY**

GOVERNOR

State Surgeon General

DISPLAY IF REQUIRED BY LAW

EXPIRATION DATE: **JANUARY 31, 2022**

Your license number is ME 144132. Please use it in all correspondence with your board/council. Each licensee is solely responsible for notifying the Department in writing of the licensee's current mailing address and practice location address. If you have not received your renewal notice 90 days prior to the expiration date shown on this license, please visit [www.FLHealthSource.gov](http://www.FLHealthSource.gov) and click "Renew A License" to renew online.

The Medical Quality Assurance Online Services Portal gives you the ability to manage your license to perform address updates, name changes, request duplicate licenses and much more.

It's simple. Log onto your MQA Online Services account today at <http://flhealthsource.gov/>. Select the "Account Login" button to access your account. For changes to your name, address or to request duplicate licenses, choose your selection from the dropdown list under "Manage My License". Your profession will open for renewal 90 days prior to your expiration date. When the renewal cycle opens for your profession, the "Renew My License" header will automatically display on your license Dashboard.

**IMPORTANT ANNOUNCEMENTS**

**ARE YOU RENEWAL READY?**

The Department of Health will now review your continuing education records at the time of license renewal.

To learn more, please visit [www.FLHealthSource.gov/AYRR](http://www.FLHealthSource.gov/AYRR)

**GROUND FOR DISCIPLINE**

You should be familiar with the Grounds for Discipline found in Section 456.072(1), Florida Statutes, and in the practice act for the profession in which you are licensed. Florida Statutes can be accessed at [www.leg.state.fl.us/Statutes](http://www.leg.state.fl.us/Statutes)

DEPARTMENT OF HEALTH  
DIVISION OF MEDICAL QUALITY ASSURANCE  
LICENSURE SUPPORT SERVICES UNIT  
4052 BALD CYPRESS WAY, BIN #C-10  
TALLAHASSEE, FLORIDA 32399-3260



\*\*\*\*\* AUTO \*\*\*\*\*

MAUREEN ELIZABETH PAUL  
9 FAIRVIEW STREET  
APT. 1  
ROSLINDALE, MA - 02131-1650

8\_1\_00001536

2.0.1.4



**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

## Application

### Application Detail

License Type:	<b>Medical Doctor</b>
Profession Number:	<b>1501 - Medical Doctor</b>
File Number:	<b>146002</b>
Application:	<b>Medical Doctor Endorsement Application</b>
Application Date:	<b>11/21/2019</b>

### Suitability Question(s)

Are you an osteopathic physician? **No**

### Application Questions

Military Veteran Fee Waiver - I have been honorably discharged from a branch of the United States Armed Forces within the previous 60 months. **No**

I am selecting NICA Non-Participating - (I understand that a \$250.00 fee will be included if I select this option.) **Yes**

I will qualify for "In Training" status at the approval of my licensure application. **No**

I plan to dispense medicinal drugs in the State of Florida for a fee or other remuneration and hereby register as required by Section 465.0276, F.S. I understand that the fee for the Dispensing Practitioner is \$100.00 over and above the required initial license fee and will submit it along with the license fee. **No**

Military Veteran Spouse Fee Waiver - I am the spouse of a military veteran who has been honorably discharged from a branch of the United States Armed Forces within the previous 60 months. **No**

**Personal Detail**

First Name: **Maureen**  
Middle/Second Name: **Elizabeth**  
Last Name/Surname: **Paul**  
Alternate Name(s): **Maureen Elizabeth Groening**  
Birthdate: **09/19/1949**  
Gender: **Female**  
Race: **White**  
Social Security Number: **[REDACTED]**

**Addresses****Mailing Address**

Address: **9 Fairview Street**  
**Apt. 1**  
**Out of State**  
**ROSLINDALE, MA**  
**02131**  
**US**

E-mail Address: **mpaulbos@gmail.com**

**Place of Practice**

Address: **Beth Israel Deaconess Med Ctr**  
**Dept. OB-Gyn**  
**330 Brookline Avenue, KS-3**  
**Out of State**  
**BOSTON, MA**  
**02215**  
**US**

**Federal Credentials Verification Services (FCVS)**

Are you using the FCVS to verify your core credentials? **Yes**

**Education History**

School Name: **Tufts University School of Medicine**  
Street Address Line 1: **136 Harrison Avenue**  
Street Address Line 2: **N/A**

City: **Boston**  
State: **MASSACHUSETTS**  
Postal/Zip: **02111**  
Country: **UNITED STATES OF AMERICA**  
Date of Graduation (mm/dd/yyyy): **05/29/1979**  
Attended From (mm/dd/yyyy): **09/08/1975**  
Attended To (mm/dd/yyyy): **03/24/1979**

#### **Additional Education Questions**

Are you currently in default on any health education loan or scholarship obligation? **No**

Have you completed the equivalent of 2 academic years of preprofessional, postsecondary education including, courses in anatomy, biology, and chemistry prior to entering medical school? **Yes**

#### **Fifth Pathway**

Did you attend an international medical school and do not possess a valid ECFMG Certificate? **No**

Did you receive a bachelor's degree from an accredited United States college or University? **No**

Did you study at a medical school which is recognized by the World Health Organization? **No**

Did you complete all of the formal requirement of the International medical school, except the internship or social service requirements, and pass part I of the National board of Medical examination or the Education Commission for Foreign Medical Graduates Examination equivalent? **No**

Did you complete an academic year of supervised clinical training in a hospital affiliated with a medical school approved by the Council on Medical Education of the American Medical Association and upon completion passed part II of the National Board of Medical Examiners examination or the Education Commission for Foreign Medical Graduates examination Equivalent? **No**

#### **Postgraduate Training 1**

Program Name: **University of Washington Medical Center**

Mailing Address: **1959 NE Pacific Street**

Program City: **Seattle**

Program State or Country: WASHINGTON  
Program Type: RESIDENCY  
Specialty Area: OBG - OBSTETRICS AND GYNECOLOGY  
Attended From (mm/dd/yyyy): 07/01/1979  
Attended To (mm/dd/yyyy): 06/30/1981  
Did you receive credit? Yes

#### Postgraduate Training 2

Program Name: Tufts Medical Center Program  
Mailing Address: 800 Washington Street  
Program City: Boston  
Program State or Country: MASSACHUSETTS  
Program Type: RESIDENCY  
Specialty Area: OBG - OBSTETRICS AND GYNECOLOGY  
Attended From (mm/dd/yyyy): 07/01/1981  
Attended To (mm/dd/yyyy): 06/30/1984  
Did you receive credit? Yes

#### Postgraduate Training 3

Program Name: University of Massachusetts Medical Center  
Mailing Address: 55 Lake Avenue North  
Program City: Worcester  
Program State or Country: MASSACHUSETTS  
Program Type: RESIDENCY  
Specialty Area: OCCUPATIONAL MEDICINE  
Attended From (mm/dd/yyyy): 01/01/1987  
Attended To (mm/dd/yyyy): 12/31/1987  
Did you receive credit? Yes

#### Exam History

Examination: National Board  
Date Passed (mm/dd/yyyy): 03/15/1980

#### United States Military and/or Public Health

Have you ever been in the United States Military and/or Public Health Service? **No**

Have you ever been disciplined by any branch of the United States Armed Services or Public Health Service? **No**

#### **Practice Employment 1**

Place of Employment: **Planned Parenthood League of Massachusetts**  
Address Line 1: **1055 Commonwealth Avenue**  
Address Line 2: **N/A**  
City: **Boston**  
State: **MA**  
Type of Employment: **Physician**  
Begin Date (mm/dd/yyyy): **07/01/2012**  
End Date (mm/dd/yyyy): **11/21/2019**

If 'to present', enter today's date.

#### **Practice Employment 2**

Place of Employment: **Beth Israel Deaconess Medical Center**  
Address Line 1: **Dept. OB-GYN, KS-3**  
Address Line 2: **330 Brookline Avenue**  
City: **Boston**  
State: **MA**  
Type of Employment: **Faculty physician and division director**  
Begin Date (mm/dd/yyyy): **12/01/2012**  
End Date (mm/dd/yyyy): **11/21/2019**

If 'to present', enter today's date.

#### **Other State Licenses 1**

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **48979**  
Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **MASSACHUSETTS**

#### **Other State Licenses 2**

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **MD19175**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **MAINE**

#### **Other State Licenses 3**

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **MD00018747**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **WASHINGTON**

#### **Other State Licenses 4**

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **035618**

Profession: **Medical Doctor**

Jurisdiction - Country: **UNITED STATES**

Jurisdiction - State: **CONNECTICUT**

### Other State Licenses 5

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **E-3126**  
Profession: **Medical Doctor**  
Jurisdiction - Country: **UNITED STATES**  
Jurisdiction - State: **ARKANSAS**

### Other State Licenses 6

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **G86493**  
Profession: **Medical Doctor**  
Jurisdiction - Country: **UNITED STATES**  
Jurisdiction - State: **CALIFORNIA**

### Other State Licenses 7

Do you now hold or have you ever held a license to practice medicine or any other profession in any US State or territory, or foreign country? **Yes**

Request verification of licensure status directly from the licensing entity or [www.veridoc.org](http://www.veridoc.org). Request international license verification(s) if you have practiced outside of the U.S. for at least two of the previous four years.

License Number: **236603**  
Profession: **Medical Doctor**  
Jurisdiction - Country: **UNITED STATES**  
Jurisdiction - State: **NEW YORK**

### Additional Employment Questions

Have you practiced medicine in any jurisdiction for two of the last four years or completed a board approved post-graduate training program within the last two years? **Yes**

#### Graduate Education

Do you currently, or have you had, responsibility for graduate medical education within the last 10 years? **Yes**

#### Initial Graduate Medical Education Responsibility and Faculty Appointments 1

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **HARVARD MEDICAL SCHOOL**

#### Initial Graduate Medical Education Responsibility and Faculty Appointments 2

List all institutions where you have had responsibility for graduate medical education or faculty appointment(s) at any medical school.

Name of Institution: **MOUNT SINAI SCHOOL OF MEDICINE OF CITY U**

#### Staff Privileges

Do you currently hold staff privileges in any hospital, health institution, clinic or medical facility? **Yes**

The facilities listed are Florida facilities. If your privileges are for a facility in another state, select "Out of State".

Name of Facility: **OUT OF STATE**

Out of State Facility: **Beth Israel Deaconess Medical Center**

#### Specialty Board Certifications 1

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF OBSTETRICS & GYNECOLOG**

Specialty Cert: **OBG - OBSTETRICS AND GYNECOLOGY**

Date Certified: **11/07/1986**

#### Specialty Board Certifications 2

Are you certified by any specialty board recognized by the American Board of Medical Specialties or specialty board approved by the Florida Board of Medicine? **Yes**

Specialty Brd: **AMERICAN BOARD OF PREVENTIVE MEDICINE**

Specialty Cert: **OCCUPATIONAL MEDICINE**

Date Certified: **01/30/1990**

#### DEA

Have you ever been denied, or surrendered, a DEA registration? **No**

**Criminal History**

Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? **No**

You must include all misdemeanors and felonies, even if adjudication was withheld. Driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

**Medicaid / Medicare**

1. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction? **No**

2. Have you been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)? **No**

3. Have you ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, F.S.? **No**

4. Have you ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program? **No**

5. Are you currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities? **No**

**Health History**

In the last five years, have you been enrolled in, required to enter into, or participated in any drug and/or alcohol recovery program or impaired practitioner program for treatment of drug or alcohol abuse that occurred within the past five years?

In the last five years, have you been admitted or referred to a hospital, facility or impaired practitioner program for treatment of a diagnosed mental disorder or impairment?

During the last five years, have you been treated for or had a recurrence of a diagnosed mental disorder that has impaired your ability to practice medicine within the past five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed physical disorder that has impaired your ability to practice medicine?

In the last five years, were you admitted or directed into a program for the treatment of a diagnosed substance-related (alcohol/drug) disorder or, if you were previously in such a program, did you suffer a relapse within the last five years?

During the last five years, have you been treated for or had a recurrence of a diagnosed substance-related (alcohol/drug) disorder that impaired your ability to practice medicine within the last five years?



**Electronic Fingerprinting**

I have been provided and read the statement from the Florida Department of Law Enforcement regarding the sharing, retention, privacy and right to challenge incorrect criminal history records and the 'Privacy Statement' document from the Federal Bureau of Investigation. **Yes**

Enter in today's date **11/21/2019**

**Medical Malpractice Question**

Have you ever had a judgment entered against you for medical malpractice where the incident(s) of malpractice occurred after November 2, 2004? **No**

**Liability Claims**

Within the last 10 years have you had any liability claim(s) or action(s) for damages for personal injury settled or finally adjudicated in an amount that exceeds \$100,000.00? **No**

**Financial Responsibility/Exemption**

Financial Responsibility **Financial Exemption**

Category II: Financial Responsibility Exemptions If you select an exemption based on # 9, you must also complete the affidavit that will be emailed to you upon submission of this application. 6. I practice medicine exclusively as an officer, employee, or agent of the federal government, the state, or its agencies or subdivisions. 7. I hold a limited license issued pursuant to s. 458.317, F. S., and practice only under the scope of the limited license. 8. I do not practice medicine in the State of Florida. 9. I meet all of the following criteria (a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years; (b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year; (c) I have had no more than two claims resulting in an indemnity exceeding \$25,000 within the previous five-year period; (d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458, F. S. or the medical practice act in any other state; and (e) I have not been subject, within the past ten years of practice, to license revocation, suspension, or probation for a period of three years or longer, or a fine of \$500 or more for a violation of Chapter 458, F. S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license, stipulation, consent order, or other settlement offered in response to or in anticipation of filing of administrative charges against a license is construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in a sign prominently displayed in my reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. See Section 458.320(5)(f), Florida Statutes, for specific notice requirements. 10. I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. (Interns and residents do not qualify for this exemption).

Financial Exemption

**8. NOT PRACTICING IN FLORIDA**

**FDA Institution**

Have you ever had any staff privileges denied, suspended, revoked, modified, restricted, not renewed or placed on probation, or have you been asked to resign or take a temporary leave of absence or were otherwise acted against by any facility? **No**

**FDA Licensing**

Have you ever had any professional license or license to practice medicine revoked, suspended, placed on probation, or other disciplinary action taken in any state, territory or country? **No**

**FDANP Denied**

Have you had any application for a medical license or professional license denied by any state board or other governmental agency of any state, territory, or country? **No**

**FDANP Investigation**

Are you currently under investigation in any jurisdiction for an act or offense that would constitute a violation of Section 458.331, Florida Statutes? **No**

**Specialty Board Discipline History**

Have you ever had any final disciplinary action taken against you by a specialty board or other similar national organization? **No**

**Year Began Practice**

Year Began Practice: **07/01/1979**

**Availability for Disaster**

Are you willing to provide health care services in special need shelters or to work with disaster medical teams during times of emergency or major disasters? **No**

**Fees**

Application	<b>\$350.00</b>
Unlicensed Activity	<b>\$5.00</b>
NICA Fee	<b>\$250.00</b>
Initial License	<b>\$350.00</b>
Total Amount Due:	<b>\$955.00</b>

**Attestation**

I state that these statements are true and correct. I recognize that providing false information may result in denial of licensure, disciplinary action against my license, or criminal penalties pursuant to Sections 456.067, 775.083, and 775.084, Florida Statutes. I state that I have read Chapters 456, 458 and 766.301-.316, Florida Statutes and Chapter 64B8, Florida Administrative Code.

I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Florida Board of Medicine information which is material to my application for licensure.

I have carefully read the questions in the foregoing application and have answered them completely, without reservations of any kind. I state that my answers and all statements made by me herein are true and correct.

Should I furnish any false information in this application, I hereby agree that such act constitutes cause for denial, suspension, or revocation of my license to practice Medicine in the State of Florida. If there are any changes to my status or any change that would affect any of my answers to this application I must notify the board within 30 days.

I understand that my records are protected under federal and state regulations governing Confidentiality of Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that my records are protected under federal and state regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it.

Attestation Answer: Yes

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

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**Dr. Maureen Elizabeth Paul**

**Date: November 27, 2019**

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REMINDER: Chapter 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department.

YOUR APPLICATION'S EXPIRATION DATE IS 11/20/2020.

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**APPLICATION SUBMITTED REMAINS DEFICIENT FOR LACK OF THE FOLLOWING:**

1. An official verification of your medical licenses from the following states have not been received:

Arkansas      New York

2. We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at <http://www.flhealthsource.gov/background-screening/> (Click on FAQs)

Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to [mqa.backgroundscreen@flhealth.gov](mailto:mqa.backgroundscreen@flhealth.gov). Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit  
Florida Department of Health  
4052 Bald Cypress Way, Bin BSU-01  
Tallahassee, FL 32399

If you have any questions, please contact me at [AnnMarie.Bissoo@flhealth.gov](mailto:AnnMarie.Bissoo@flhealth.gov), or call 850-617-1909. The Florida Board of Medicine has assigned **146002** as your **tracking number**. Please indicate this number if you leave a message and try to ensure that other sources include it on their communications to us as well.

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX : (850) 488-0596



**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

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February 11, 2020

Maureen Elizabeth Paul, M.D.  
9 Fairview Street, Apt. 1  
Roslindale, MA 02131

Dear Dr. Paul:

Congratulations! You have completed the application process for licensure as a Medical Doctor in the State of Florida. Your license number is ME144132. You will receive your printed license within two weeks. Within 24 hours, you can verify your license online at [www.FLHealthSource.gov](http://www.FLHealthSource.gov).

The current license biennium expires 01/31/2022. It is your obligation to complete any continuing education (CE) that is required. You must have completed the required CEs prior to renewing your license. Visit [www.FLHealthSource.gov/AYRR](http://www.FLHealthSource.gov/AYRR) and become familiar with the renewal process. Your CE requirements can be found at [www.FLHealthSource.gov/requirements](http://www.FLHealthSource.gov/requirements).

Licenses are renewed on a biennial basis. Approximately 90 days prior to the expiration date shown on your license, a postcard reminder will be mailed to the last known address on file for you. The U.S. Post Office does NOT forward state mail. Address changes may be submitted electronically through your MQA Online Services Portal account. If you have not registered for an account in the new system, go to [www.FLHealthSource.gov/mqa-services](http://www.FLHealthSource.gov/mqa-services) and select "No" to get started. If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User.

**Practitioner Profile – Section 456.041, Florida Statutes, requires specific information be compiled and published online about you.** In carrying out this legislative mandate to publish practitioner profiles, we want to ensure the information that we publish is accurate. You should receive your license within two weeks. You can review your practitioner profile by accessing your MQA Online Services Account at <http://www.flhealthsource.gov/>. Please select "Account Login" from the top of the page. In order to use the online services portal, you will need to complete a one-time registration process if you have not done so already. Once you have gained entry onto your account, please select "Review, Update & Confirm Profile" under "Manage My License". You are **required to review** and confirm or make changes to the information that will be published in your practitioner profile. If you see the statement "The practitioner did not provide this mandatory information," you are **required to provide** the missing information. We cannot accept curriculum vitae or resumes in place of your providing specific information. Changes, excluding education and training, year began practicing, and liability claims, can be made to your profile electronically. You may also submit changes by mail to the Department of Health, Licensure Support Services, 4052 Bald Cypress Way Bin #C10, Tallahassee, Florida 32399-3260. If you have questions, please call (850) 488-0595, option 3, Monday through Friday, 8:00 a.m. to 6:00 p.m., EST. You may also email us at [MQAOnlineService@flhealth.gov](mailto:MQAOnlineService@flhealth.gov).

According to section 456.041(8), Florida Statutes, you have thirty (30) days from receipt of this letter to submit changes to the department. If you do not make changes within thirty (30) days, your profile will be automatically published.

Thank you for applying for licensure in Florida. If you have additional questions, you may contact the board office at (850) 245-4131 or at the address listed below

Welcome to Florida,

Board of Medicine Staff

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**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX : (850) 488-0596



**Accredited Health Department**  
Public Health Accreditation Board

## **Bissoo, AnnMarie**

---

**From:** Clayton, Connie  
**Sent:** Wednesday, November 27, 2019 4:22 PM  
**To:** Bissoo, AnnMarie  
**Attachments:** Paul, Maureen Elizabeth-CV-Profile-2019-11-20-2.pdf

**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

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January 22, 2020

Dr. Maureen Elizabeth Paul  
9 Fairview Street  
Apt. 1  
Roslindale, MA 02131

Dear Dr. Paul:  
File #: 146002

Thank you for considering Florida for physician licensure. Your application has been received and processed. However, the application is incomplete and remains deficient for the following:

We have not received your Livescan results. If you have already had your electronic fingerprinting completed, please allow 24 – 72 hours for receipt of your results. Should your Criminal Background Check disclose an arrest record(s), you will need to provide documentation related to each criminal event revealed in your background, if you have not already done so. You can find a detailed description of documents that will be required by visiting the FAQs on the Background Screening Website at <http://www.flhealthsource.gov/background-screening/> (Click on FAQs)

Note: Criminal History will be reviewed by the Background Screening Unit, not the Board Office. Please email all criminal history documents to [mqa.backgroundscreen@flhealth.gov](mailto:mqa.backgroundscreen@flhealth.gov). Any original certified documents must be mailed to the following address:

Attn: Background Screening Unit  
Florida Department of Health  
4052 Bald Cypress Way, Bin BSU-01  
Tallahassee, FL 32399

After all deficient items are received; your file will be submitted for a secondary review. You will be notified if additional information is required.

Section 456.013(1)(a), Florida Statutes, provides that an incomplete application shall expire one year after initial filing with the department. Your application will expire 11/20/2020.

If you have any questions, please contact me at [AnnMarie.Bissoo@flhealth.gov](mailto:AnnMarie.Bissoo@flhealth.gov), or call 850-617-1909.

Sincerely,

*Ann-Marie Bissoo*

Ann-marie Bissoo  
Regulatory Specialist II

---

**Florida Department of Health**

Division of Medical Quality Assurance • Bureau of HCPR  
4052 Bald Cypress Way, Bin C03 • Tallahassee, FL 32399-3253  
PHONE: (850)245-4131 • FAX : (850) 488-0596



**Mission:**

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts .



**Ron DeSantis**  
Governor

**Scott A. Rivkees, MD**  
State Surgeon General

**Vision:** To be the **Healthiest State** in the Nation

---

November 27, 2019

Maureen Elizabeth Paul, M.D.  
9 Fairview Street  
Apt. 1  
Roslindale, MA 02131

Dear Dr. Paul:  
File: 146002

Thank you for considering Florida for physician licensure. Your application for medical licensure has been received. The application is incomplete for the reasons set out in the attached deficiency notice. Please address these deficiencies as soon as possible to avoid delay in processing your application.

Information received by this office may require additional explanation or documentation to determine licensure eligibility. After all requested documentation is received, your application will be submitted for supervisory review. We will notify you if additional information is required.

Applicants with a history of malpractice, criminal activity, discipline, physical or mental impairment, unfavorable evaluations, or other matters that need explanation may require a personal appearance before the Board of Medicine Credentials Committee for determination of licensure eligibility. If your appearance is required, you will be notified in writing once your application is complete.

You can now follow the progress of your application through our website at: [www.FLHealthSource.gov/mqa-services](http://www.FLHealthSource.gov/mqa-services). If you are a returning user, select "Yes" and enter the user ID and password you selected during the registration process under Returning User. If you did not apply for licensure through this screen, select "No" and follow the prompts to create an account. You must have a valid email address to create your account.

Once you are logged in, you will be prompted to add your application to your account. Once you have successfully added your application, you will be directed to your dashboard. Under the "Additional Activities" section, select "Check Application Status" to review any open deficiencies, upload documents or print out instructional documents.

**THIS IS IMPORTANT:** Your application will remain incomplete until all deficiencies are completed. In addition, you are required to notify the Board office immediately in writing of any occurrence(s) that would in any way change or affect any answer given in the application or an answer provided in response to any of our direct questions to you.

If you have any questions, please contact me at [AnnMarie.Bissoo@flhealth.gov](mailto:AnnMarie.Bissoo@flhealth.gov), or call 850-617-1909.

Sincerely,

*Ann-Marie Bissoo*

Ann-Marie Bissoo  
Regulatory Specialist II

Enclosure(s)

## Office of the Professions

### Verification Searches

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The information furnished at this web site is from the Office of Professions' official database and is updated daily, Monday through Friday. The Office of Professions considers this information to be a secure, primary source for license verification.

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#### License Information \*

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01/08/2020

**Name :** PAUL MAUREEN ELIZABETH

**Address :** NEW YORK NY

**Profession :** MEDICINE

**License No:** 236603

**Date of Licensure :** 06/20/2005

**Additional Qualification :**

**Status :** NOT REGISTERED

**Registered through last day of :**

**Medical School:** TUFTS UNIVERSITY    **Degree Date :** 05/20/1979

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(Use your browser's back key to return to licensee list.)

\* Use of this online verification service signifies that you have read and agree to the [terms and conditions of use](#). See [HELP glossary](#) for further explanations of terms used on this page.

**Note:** The Board of Regents does not discipline *physicians(medicine)*, *physician assistants*, or *specialist assistants*. The status of individuals in these professions may be impacted by information provided by the NYS Department of Health. To search for the latest discipline actions against individuals in these professions, please check the New York State Department of Health's [Office of Professional Medical Conduct](#) homepage.

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Further information on physicians may be found on the following external sites (The State Education Department is not responsible for the accuracy or completeness of information located on external Internet addresses.):

[American Board of Medical Specialties](#)

[American Medical Association:](#)

- For the general public: [AMA Physician Select, On-line Doctor Finder](#)

- For organizations that verify physician credentials: [AMA Physician Profiles](#)

[American Osteopathic Association, AOA-Net](#)

[Association of State Medical Board Executive Directors-\(A.I.M."DOCFINDER"\)](#).

[New York State Department of Health Physician Profiles](#)

The following sites provide additional information concerning the medical profession:

[CLEAR \(Council on Licensure, Enforcement and Regulation\)](#)

[Federation of State Medical Boards](#)



146102  
Dane  
B

November 12, 2019

**STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH**

MEDICINE BOARD

2019 NOV 25 PM 1:07

FLORIDA BOARD OF MEDICINE  
4052 BALD CYPRESS WAY  
BIN #C03  
TALLAHASSEE, FL 32399-3253

**LICENSURE VERIFICATION**

This is to certify that the records of the Connecticut Department of Public Health indicate that:

**MAUREEN E. PAUL**

Was issued a Connecticut:	Physician/Surgeon
Date Issued:	October 4, 1996
License Number:	35618
Basis for Licensure:	Endorsement
Expiration Date:	September 30, 1999
Status of License:	INACTIVE
Public Disciplinary History	No
Subject of a Pending Investigation	No

Please note that this is the only verification provided by this office. The Connecticut Department of Public Health does not affix a raised seal to this document. Please note that the information contained in this letter can be verified online at <https://www.elicense.ct.gov>.

Sincerely,

*Stephen B. Carragher*

Stephen B. Carragher  
Public Health Services Manager  
Practitioner Licensing and Investigations Section



Ann B

1412902 AS

# ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 • (501) 296-1802 • FAX (501) 603-3555  
www.armedicalboard.org

MEDICINE BOARD

2019 DEC 20 PM 12:44

December 12, 2019

Maureen Elizabeth Paul, M.D.

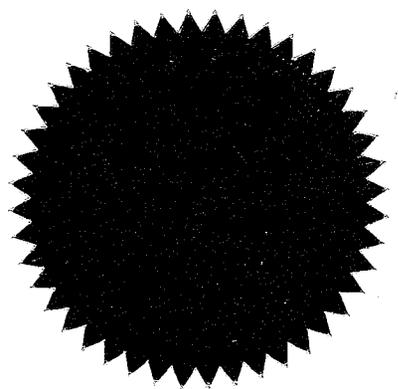
### CERTIFICATION

I, Amy E. Embry, Executive Director of the Arkansas State Medical Board, do hereby certify that the enclosed certification of the above referenced practitioner is true and correct as same appears on file in this office.

Witness my hand and official seal of the Board, this 12<sup>th</sup> day of December 2019.

ARKANSAS STATE MEDICAL BOARD

BY: Amy E. Embry  
Amy E. Embry  
Executive Director





# ARKANSAS STATE MEDICAL BOARD

---

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 (501) 296-1802 FAX: (501) 603-3555

[www.armedicalboard.org](http://www.armedicalboard.org)

## Detailed License Verification

Queried on: Thursday, December 12, 2019 at: 4:05 PM

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### General Information

Name: Maureen Elizabeth Paul, M.D.  
Specialty: Obstetrics & Gynecology

---

### Address Information

Mailing Address: 815 Eddy Street  
Address 2: Suite 300  
City/State/Zip: San Francisco, CA 94109  
Phone: (415) 202-7220  
Fax: (415) 776-1449

---

### License Information

License Number: E-3126  
Original Issue Date: 12/7/2001  
Expiration Date: 9/30/2004  
Basis: Exam  
License Status: Inactive  
License Category: Expired

---

No Information Found for: License Board History

146002  
Ann Marie

*[Handwritten mark]*

THE UNIVERSITY OF THE STATE OF NEW YORK  
THE STATE EDUCATION DEPARTMENT  
DIVISION OF PROFESSIONAL LICENSING SERVICES  
89 WASHINGTON AVENUE  
ALBANY, NEW YORK 12234

Date: 01/08/20  
Profession: 6013  
License no.: 236603  
2020 JAN 13 AM 11:27

MEDICINE BOARD

TO WHOM IT MAY CONCERN:

You have inquired as to whether or not a license to practice  
MEDICINE in New York State has  
ever been issued to PAUL, MAUREEN ELIZABETH

This person is licensed and not currently registered.  
Our records indicate the following:

License number: 236603 Licensure date: 06/20/2005

Last registration expired : 08/31/14

*[Handwritten mark]*

Disciplinary information: No charges have been preferred against  
this licensee

*[Handwritten signature]*

01/08/20  
Education Credentials Specialist

ORIGINAL

## Department of Health

### Professional Misconduct and Physician Discipline



New Physician Search

**Search**

**0 documents found**

Physician Records

**Results -**

On: 1/8/2020 5:15 PM

**You searched for:** Last Name: Paul First Name: Maureen Middle Name: \_\_\_\_\_  
License: 236603 Type: \_\_\_\_\_  
Effective Date From: \_\_\_\_\_ Effective Date To: \_\_\_\_\_  
Update Date From: \_\_\_\_\_ Update Date To: \_\_\_\_\_

**\* If there is a list of name(s) above, click on each name to see the disciplinary information.  
If there is no list of names, there is no public disciplinary action that matches what you entered for the search.**

**Reminder: This database contains public disciplinary actions for 1990 and later.**

---

[Return to Professional Misconduct and Professional Discipline](#)  
[Return to Welcome Page](#)

Send questions or comments to:  
[opmc@health.ny.gov](mailto:opmc@health.ny.gov)

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[Info for Consumers](#) / [Info for Providers](#) / [Info for Researchers](#) /  
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Questions or comments: [nhinfo@health.ny.gov](mailto:nhinfo@health.ny.gov)

Revised: March 2017

**Department of Health**

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