File # 17543

New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE IF YOU HAVE A CHANGE OF ADDRESS. PLEASE PRINT.

*****NOTE.....Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: _Donna L. Burkett, MD_____

N.H. License Number:___ 16261_____

Business Name: __Planned Parenthood of Northern New England_____

[X] Address:__784 Hercules Dr., Ste 110_____

_____Colchester, VT 05446 _____

_____Office telephone: _802-448-9717____

Business Fax Number: _____ Business E-Mail: [redacted]

DLB [ ] Home Address: ___[redacted]_____

_____[redacted] ___Home telephone: _[redacted]____

Specialty: _Family Medicine_____Board certified: __2015, exp 2025_____

Hospital affiliations: ___UVM, Burlington, VT_____

_____

In what other states do you hold a current license: ___Vermont, Maine_____

_____

File 17543

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE. PLEASE PRINT.

*****NOTE.....Please mark the box next to the address you would prefer to list as your mailing address.**

Physician Name: Donna L Burkett MD

N.H. License Number: 16261

Business Name: Planned Parenthood Northern New England

☑ Address: 128 Lakeside Ave Suite 301

Burlington, VT 05401

Office telephone: 802-448-9717

Business Fax Number: [redacted] Business E-Mail: [redacted]

☑ Home Address: Same as above.

Home telephone:

Specialty: Family Medicine Board certified: Yes

Hospital affiliations: Fletcher Allen

In what other states do you hold a current license: Vermont, Maine, West Virginia, Virginia, North Carolina and South Caroline

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

August 7, 2013

DONNA L BURKETT MD
[redacted]

Dear Dr. Burkett:

Congratulations, the New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 16261 is dated August 7, 2013 and expires June 30, 2015. Please be advised that your wallet card will be mailed to you as soon as it is available.

You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

Uniform Application for Physician Licensure

UA Username dburkett **Date Submitted** 7/5/2013
FCVS Status Applicant has an FCVS Packet

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

7/8/13

1. Full Name (use no initials)

Last Name Burkett
First Name Donna
Middle Name Lynn
Suffix
Maiden Name
M.D. [X] **D.O.** [ ]

All other names used

First	Middle	Last	Suffix

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business
[X] **Public Access** **Street** 603 BILTMORE AVE
[X] **Mailing**
City ASHEVILLE **State/Province** NC **Zip Code** 28801-4603
Country USA
Telephone [redacted]
Alternate Phone

Home
[ ] **Public Access** **Street** 603 BILTMORE AVE
[ ] **Mailing**
City ASHEVILLE **State/Province** NC **Zip Code** 28801-4603
Country USA
Telephone [redacted]
Alternate Phone

BURKETT, DONNA

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted]	[redacted]	[redacted]	[redacted]
Date of Birth (mm/dd/yyyy)	Birth City	Birth State/Province	Birth Country

F	[redacted]	[redacted]		
Gender	Social Security Number	NPI	Are you a U.S. Citizen?	☐ Yes ☐ No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1

School Name	University of North Carolina at Chapel Hill School of Medicine
Address	Office of Student Affairs/Guy Winstead Campus Box #7000 121 MacMider Boulevard
City	Chapel Hill
State/Province	NC
ZIP Code	27599-7000
Country	USA
Attendance Dates	**From (mm/yyyy)** 08/1991 **To (mm/yyyy)** 05/1995
Graduation Date	5/14/1995
Degree	MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

Institution name where rotations performed			
Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Oregon Health Sciences University
Hospital Address 3181 SW Sam Jackson Park Road

City Portland
State/Province Oregon
ZIP Code 97201-3098
Country USA

PGY: (e.g., 1, 2, 3, etc.) ☐ **Internship** ☒ **Residency** ☐ **Fellowship** ☐ **Research** ☐ **Other**

Department/Specialty Family Practice

From: 07 /1995 **To:** 06 /1998 **Successfully Completed?** ☒ **Yes** ☐ **No** **In Progress** ☐

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/1997	☐ P	☐ F	1
USMLE Step 2			☐ P	☐ F	1
USMLE Step 3			☐ P	☐ F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	Issue Date	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province** NC ✓	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**	Full License		
	License Number 200100124	**Status**	Active	**Issue Date**	2/1/2001		
2	**State/Province** VA	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**	Full License		
	License Number 0101241288	**Status**	Active	**Issue Date**	2/1/2007		
3	**State/Province** SC	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**	Full License		
	License Number 29999	**Status**	Active	**Issue Date**	9/1/2007		
4	**State/Province** WV ✓	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**	Full License		
	License Number 22710	**Status**	Active	**Issue Date**	5/1/2007		
5	**State/Province** OR ✓	**Practitioner Type (MD, DO, etc.)**	MD	**Type of License (Full, Temporary, etc.)**	Full License		
	License Number MD20096	**Status**	Expired	**Issue Date**	10/18/1996		

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 07 Year: 1995 To: Month: 06 Year: 1998 In Progress ☐	**Practice/Employment Name** Oregon Health Sciences University (or list non-working time as indicated above) **Practice/Employment Address** 3181 SW Sam Jackson Park Rd **City** Portland **State/Province** Oregon **ZIP Code** 97239 **Country** USA **Position and Department** Resident-Family Medicine **Percent Clinical:** 99% **Percent Administrative:** 1% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other** training
2 From: Month: 07 Year: 1998 To: Month: 08 Year: 1998 In Progress ☐	**Practice/Employment Name** travel between jobs (or list non-working time as indicated above) **Practice/Employment Address** 3522 SE Brooklyn **City** Portland **State/Province** Oregon **ZIP Code** 97202 **Country** USA **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**
3 From: Month: 08 Year: 1998 To: Month: 12 Year: 1999 In Progress ☐	**Practice/Employment Name** Providence Health Systems, North Portland (or list non-working time as indicated above) **Practice/Employment Address** North Portland Family Medicine Clinic **City** Portland **State/Province** Oregon **ZIP Code** 97217 **Country** USA **Position and Department** Physician-Family Medicine **Percent Clinical:** 95% **Percent Administrative:** 5% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 01 Year: 2000 To: Month: 04 Year: 2001 In Progress ☐	**Practice/Employment Name** Family Leave/pregnancy and childbirth/seeking employment/moving (or list non-working time as indicated above) **Practice/Employment Address** 105 Sunset Dr. **City** Asheville **State/Province** North Carolina **ZIP Code** 28804 **Country** USA **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
5 From: Month: 04 Year: 2001 To: Month: 02 Year: 2005 In Progress ☐	**Practice/Employment Name** WNC OB-Gyn and Family Practice (or list non-working time as indicated above) **Practice/Employment Address** 17 McDowell St. **City** Asheville **State/Province** North Carolina **ZIP Code** 28801 **Country** USA **Position and Department** Physician-n/a **Percent Clinical:** 95% **Percent Administrative:** 5% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other** Partner

Dates: From/To	Practice/Employment
6 From: Month: 02 Year: 2005 To: Month: 06 Year: 2005 In Progress ☐	**Practice/Employment Name** looking for parttime work and being stay-at-home parent (or list non-working time as indicated above) **Practice/Employment Address** 17 Panola St. **City** Asheville **State/Province** North Carolina **ZIP Code** 28801 **Country** USA **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
7 From: Month: 07 Year: 2005 To: Month: 05 Year: 2013 In Progress ☐	**Practice/Employment Name** MAHEC (or list non-working time as indicated above) **Practice/Employment Address** 118 WT Weaver Blvd **City** Asehville **State/Province** North Carolina **ZIP Code** 28804 **Country** USA **Position and Department** Faculty Physician-Family Medicine **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☒ **Affiliation** ☐ **Other** part-time faculty

Dates: From/To	Practice/Employment
8 From: Month: 07 Year: 2006 To: Month: Year: In Progress ☒	**Practice/Employment Name** Planned Parenthood Health Systems, Inc (or list non-working time as indicated above) **Practice/Employment Address** 603 Biltmore Avenue **City** Asheville **State/Province** North Carolina **ZIP Code** 28801 **Country** USA **Position and Department** Affiliate Medical Director-Medical Services **Percent Clinical:** 5% **Percent Administrative:** 95% **Employment** ☒ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

This form should be sent to the state board you are applying to, NOT to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

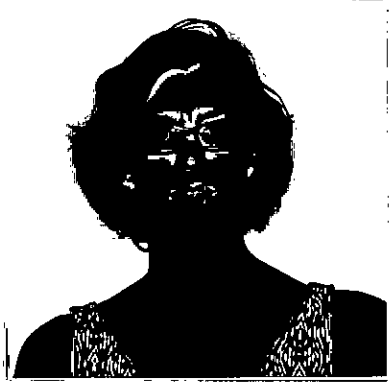
I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.



Donna L. Burkett

Applicant's signature (must be signed in the presence of a notary)

Burkett

Applicant's printed last name

Donna L.

Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

6/28/2013

Date of signature (must correspond to date of notarization)

Notary

State of North Carolina, County of [redacted].

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 28th day of June 2013.

Notary Public Signature: Sandra L Epperson

My Notary Commission Expires: 12-7-2013

SANDRA L. EPPERSON NOTARY PUBLIC MOORE COUNTY, N.C. (NOTARY PUBLIC SEAL)

ADDENDUM TO APPLICATION

RECEIVED
JUL 15 2013
NH BOARD

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or attach an additional 8 1/2" x 11" sheet(s) if necessary.**

	YES	NO
1. Have you been actively engaged in the practice of clinical medicine within the past 12 months?	✓	
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	✓	
3. Have you ever, for any reason, lost American Specialty Board Certification?		✓
4. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		✓
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, indicate how many).		✓
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?		✓
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school?		✓
8. Have you ever failed any national medical licensure examination, or any part of that examination, state board examination or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.)		✓
9. Have you ever failed a foreign licensing or certification examination?		✓
10. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		✓
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action?		✓
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		✓

	YES	NO
13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action?		✓
14. Have you ever withdrawn an application for licensure, hospital privileges or appointment for any reason?		✓
15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies?		✓
16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been charged, investigated or warned by a state or federal agency based on controlled substance issues?		✓
17. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine?		✓
18. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?		✓

Anticipated Practice Location(s) (if known):

See attached

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory.

SOCIAL SECURITY NUMBER: [redacted]

Donna L Burkett — Burkett — 7/11/2013

Applicant's Signature | Applicant's Printed Last Name | Date of Signature

For Board Use Only:

Application Received: July 15, 2013, 2013 Fee Paid: $300 Check#: 3107

License Number: _____ Date of Issue: _____

DONNA L. BURKETT, MD
Curriculum Vitae
Affiliate Medical Director
Planned Parenthood Health Systems, Inc.
603 Biltmore Ave.
Asheville, NC 28801
[redacted]

EDUCATION

1995-1998	Residency in Family Medicine, Oregon Health Sciences University (OHSU), Portland, OR. See below for detail.
1991-1995	Medical Degree, University of North Carolina School of Medicine, Chapel Hill, NC
1986-1990	B.S. Chemistry/B.A. French, Mars Hill College, Mars Hill, NC

EMPLOYMENT

Anticipated Sept 2013 **Medical Director, Planned Parenthood of Northern New England**

Feb 2011-present **Consultant, Planned Parenthood Federation of America,** Medical Services Department, writing and editing Primary Care Standards and Guidelines

July 2006- Aug 2013 **Affiliate Medical Director, Planned Parenthood Health Systems, Inc**, Regional Planned Parenthood in NC, SC, VA and WV. Duties include:

- Oversight and evaluation of physician and clinical employees
- Quality and risk management oversight for high-risk services in 12 health centers through 4 states
- Protocol review and oversight
- New clinical program innovation and implementation

July 2005-May 2013 **Part-time faculty, MAHEC Family Health Center**, Asheville, NC. Duties include:

- Starting and running vasectomy clinic
- Precepting residents in Family Practice clinic
- Participating in Obstetrical call
- Some didactic responsibilities for the reproductive health curriculum

BURKETT, DONNA

February 2005 – June 2005 Family leave/volunteer at ABCCM, local free clinic

2001-2005 **Family Physician and Administrative Physician, WNC OB-Gyn and Family Practice**, Asheville, NC. Activities included:

- Established FP side of practice and built a very busy practice over several years
- Scope of practice included care of men, women, and children, primary gynecological care, obstetrical care, vasectomy, circumcision, and minor dermatological care and procedures
- As a partner, took on the administration of a failing practice and brought it into improved fiscal conditions through hiring better qualified management staff, changing billing system to more up-to-date one and internalized billing, bringing the AR DSO from 90+ to 40-50 in 1-year period, developing standard practices for quality and efficiency in the practice
- Established a teaching vasectomy service
- Periodically provided abortions at a partner's private practice

Jan 2000 – April 2001 Family Leave/volunteer as Preceptor at OHSU Family Medicine Department prior to move to NC

1996 - 2000 **All Women's Health Center,** Portland and Eugene, OR. Part-time, contractual, abortion procedural work in a non-profit reproductive health organization.

1998 - 1999 **Family Practitioner, North Portland Clinic, Providence Health System**, Portland, OR. Full-time clinician in an underserved community clinic. Duties included:

- Active obstetrical practice
- Call, hospital management of patients
- Chair – End of Life Improvement committee
- Participant – several medical informatics endeavors

July and August 1998 Extended vacation, following residency

1995- 1998 **Family Practice Resident, OHSU**, Portland, OR. Full-time. In-patient, out-patient, surgical, rural and urgent care rotations. Extra duties:

- Chief Resident 1997-1998 – scheduling, arranging conferences, teaching, and trouble-shooting
- Writing Abortion Curriculum for Ob/Gyn and Family Practice Residents in conjunction with Faculty Director

ADDITIONAL EDUCATIONAL EXPERIENCE

2004-2005	**Advanced Life Support in Obstetrics (ALSO) Instructor Course and Instructor Candidate** teaching completed, American Academy of Family Physicians (AAFP). Adult learning model utilized.
2003	**Fundamentals of Management Course**, AAFP. An intensive program designed to train FPs to become more effective managers and leaders.
Spring 1988	**Semester Abroad, Institute d'Etude Francais**, Avignon, FRANCE

PROFESSIONAL MEMBERSHIPS

2011-present	Member, WPATH (World Professional Association of Transgender Health)
1998-present	Diplomate, American Board of Family Practice
1998-present	Member, American Academy of Family Physicians
2006-present	Member, Association of Reproductive Health Professionals
2001-present	Member, NC Academy of Family Physicians
2001-5, 2012 –present	--Member, Western North Carolina Medical Society
1992-2002	Member, American Medical Women's Association

VOLUNTEER SERVICE

2010 -- present	Member, Medical Advisory Board, AFAXYS
2012 – present	Member, Federation Patient Safety Committee, ARMS, Inc
2008 – present	Multiple short-term committees, PPFA
2005-2012	Board Member of children's school, serving preschool through 8th grade. Chair 2008-2011. Led the school through a director transition and through implementation of Policy Governance.
2003 – present	various volunteer activities, same school
2005 – present	Reproductive health educator, various schools and church

INTERESTS AND ACTIVITIES

[redacted]

REFERENCES

Available upon request

Planned Parenthood®
of Northern New England

PPNNE Health Center Address & Contact Information

NH Sites	Mailing Address	Physical Address	Telephone & Fax 603
Claremont	136 Pleasant St, Claremont, NH 03743	Same	**T.** 542-4568 **F.** 542-4438
Derry	4 Birch St, Derry, NH 03038	Same	**T.** 434-1354 **F.** 434-4290
Exeter	108 High St, Exeter, NH 03833	Same	**T.** 772-9315 **F.** 772-8091
Keene	8 Middle St, Keene, NH 03431	Same	**T.** 352-6898 **F.** 325-0682
Manchester	24 Pennacook St, Manchester, NH 03104	Same	**T.** 669-7321 **F.** 621-0097
West Lebanon	89 South Main St, W. Lebanon, NH 03784	Same	**T.** 298-7766 **F.** 298-5976

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

July 24, 2013

To Whom It May Concern:

This letter verifies Donna Lynn Burkett, M.D. (NPI: 1760445506) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2015*

* Three Year extension of certification earned by completion of MC-FP requirements.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Meeting Requirements

Beginning in 2004 with the family physicians who performed successfully on the Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next MC-FP examination. The prior requirements for licensure and CME are incorporated into the requirements of MC-FP.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

Subscribed and sworn before me this 24 day of July, 2013 Signature Janice Thomas, Notary Public Printed Name: Janice Thomas My commission expires: April 2, 2017

1648 McGrathiana Pkwy, Ste. 550 | Lexington, KY 40511-1247 | Ph: 859-269-5626 or 888-995-5700 | Fax: 859-335-7516 | www.theabfm.org

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

July 15, 2013

To Whom It May Concern:

This letter verifies Donna Lynn Burkett, M.D. (NPI: 1760445506) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 10, 1998 - Jul 22, 2005
Jul 23, 2005 - Dec 31, 2015*

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The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

RECEIVED

JUL 15 2013

NH BOARD

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	07-31-2014	$551

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,2N,3 3N,4,5	PRACTITIONER	07-11-2011

BURKETT, DONNA LYNN MD
PLANNED PARENTHOOD HEALTH SYSTEMS, INC
603 BILTMORE AVE
ASHEVILLE, NC 28801

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacturer, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, OR BUSINESS ACTIVITY, AND IS NOT VALID AFTER THE EXPIRATION DATE.

CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C, 20537

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ASHEVILLE, NC 28801

U.S. Department of Justice

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Drug Enforcement Administration

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (05/04)

RECEIVED
MAY 18 2015
RECEIVED
JUN 09 2015
JUN 06 2015
NH BOARD
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
121 South Fruit Street, Suite 30
Concord, NH 03301-2412

RENEWAL APPLICATION

For expiration on: 6/30/2017

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 4/16/15 Check # 15122

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in business or home address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y
(If yes, provide proof of board certification.)
Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) ~~NC, VA, SC, WV~~, ME, VT

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 16261

File #: 17543

☑ Work Address
DONNA L BURKETT, MD
PLANNED PARENTHOOD NORTH
128 LAKESIDE AVE, SUITE 301
BURLINGTON, VT 05401

☐ Home Address
[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 802-448-9717
Business Fax Number: [redacted]
Business Email Address: [redacted]

Phone: [redacted]

Hospital Affiliations: ***Please list city and state where hospital is located. Check off type of privileges you hold for each hospital.**

Hospital Privileges			Full	Courtesy	Consult	Other
FLETCHER ALLEN	BURLINGTON	VT	☑	☑	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Social Security Number:** [redacted]

Please answer each of the following questions. **If your answer to any question is "Yes", you must provide a complete written explanation of the circumstances including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s). attached	✓	
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	
13. Have you completed the New Hampshire Department of Health and Human Services, Division of Public Health's Physician Licensure Survey?	✓	

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted)

3/31/15
Date

American Board of Family Medicine, Inc.

Donna Lynn Burkett, M.D.

is a Diplomate of this Board and
having met its continuing requirements is hereby

Recertified

as a

Diplomate

2005-2015

Chair

President

Practice Locations for Donna Burkett MD

ME Sites	Mailing Address / Physical Address	Telephone & Fax 207
Biddeford	281 Main St, Biddeford, ME 04005	T. 282-6620 F. 283-4408
Portland	443 Congress St, 2nd Floor Portland, ME 04101	T. 797.8881 F. 773-1697
Sanford	886 Main St, Ste. 302, Sanford, ME 04073	T. 324-9385 F. 324-2818
Topsham	4 Bowdoin Mill Island, Ste. 101, Topsham, ME 04086	T. 725-8264 F. 729-6117
NH Sites	**Mailing Address / Physical Address**	**Telephone & Fax 603**
Claremont	136 Pleasant St, Claremont, NH 03743	T. 542-4568 F. 542-4438
Derry	4 Birch St, Derry, NH 03038	T. 434-1354 F. 434-4290
Exeter	108 High St, Exeter, NH 03833	T. 772-9315 F. 772-8091
Keene	8 Middle St, Keene, NH 03431	T. 352-6898 F. 325-0682
Manchester	24 Pennacook St, Manchester, NH 03104	T. 669-7321 F. 621-0097
VT Sites	**Mailing Address / Physical Address**	**Telephone & Fax 802**
Barre	90 Washington St, Barre, VT 05641	T. 476-6696 F. 476-6419
Bennington	194 North St, Bennington, VT 05201	T. 442-8166 F. 442.2206
Brattleboro	402 Canal St, Brattleboro, VT 05301	T. 257-0534 F. 257-4342
Burlington	183 St Paul St, Burlington, VT 05401	T. 863-6326 F. 863-4951
Hyde Park	PO Box 347, Hyde Park, VT 05655 / 213 Main St	T. 888-3077 F. 888-6912
Middlebury	PO Box 1, Middlebury, VT 05753 / 1641 Rte 7 South	T. 388-2765 F. 388-0411
Newport	PO Box 932, Newport, VT 05855 / 79 Coventry St	T. 334-5822 F. 334-5312
Rutland	6 Roberts Ave, Rutland, VT 05701	T. 775-2333 F. 775-2044
St. Albans	80 Fairfield St, St Albans, VT 05478	T. 527-1727 F. 527-1729
St. Johnsbury	501 Portland St, St Johnsbury, VT 05819	T. 751-7821 F. 748-0353
White River	PO Box 218,WRJ, VT, 05001/79 South Main St	T. 281-6056 F. 291-9130
Williston	75 Talcott Rd, Suite 10, Williston, VT 05495	T. 879-4800 F. 879-4433

JUN 0 2 2017

RECEIVED
JUN 0 2 2017
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2412

RENEWAL APPLICATION

For expiration on: 6/30/2019

Renewal Fee: $350.00

For Office Use Only: Date Pd 6-2-17 Check # 160720

If you **DO NOT** wish to renew your license, check here. ☐

If you choose not to renew, your license will be placed on inactive status. To reactivate the license, you will be required to file a reinstatement application.

The following information represents the information on file for you with the Board of Medicine. **Please make any necessary changes. Please note that pursuant to RSA 329:16-f, all licensees must inform the Board of any change in business or home address within 30 days of the change.**

Specialty: FP

Currently Board Certified? (Y/N) Y

(If yes, provide proof of board certification.)

Please list ABMS Board Specialty: FP

Currently licensed in the states of: (2 letter state abbrev.) ME, VT

You must provide both home and business street address. P.O. Boxes are not acceptable without a street address provided. ***Please mark the box next to the address you would prefer to list as your mailing address.***

License #: 16261

File #: 17543

☑ Work Address

DONNA L BURKETT, MD
PLANNED PARENTHOOD NORTH
784 HERCULES DR - STE 110
COLCHESTER, VT 05446

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 802-448-~~9707~~ 9700

Business Fax Number: [redacted]

Business Email Address: [redacted]

Phone: [redacted]

Hospital Affiliations: ***__Please list city and state where hospital is located.__

Hospital Privileges

~~FLETCHER ALLEN~~ UVM-MC BURLINGTON VT

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. **Last four (4) of your Social Security Number:** [redacted]

Please answer each of the following questions. **Affirmative answers to any question between 1 and 10 requires a complete written explanation of the circumstances, including any required documents. DO NOT RESUBMIT INFORMATION REPORTED ON A PRIOR RENEWAL APPLICATION.

In the past 24 months OR since you last reported to the Board of Medicine if greater than 24 months:

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate?		✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).	✓	
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: NH VT Expiration Date: ~~FB4132015~~ 7-31-17 7-31-19 ME 7-31-19	✓	

****Pursuant to RSA 125:25-c, I, please attach a list of ALL diagnostic and therapeutic services in which you have an ownership interest.**

I HEREBY CERTIFY UNDER PENALTY OF UNSWORN FALSIFICATION THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

Donna L. Burke

Signature of Licensee (Signature Stamp Not Accepted)

5/14/17

Date

Physician Renewal 03/06/2019

MEDP Disciplinary Action

MEDP With regards to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation? N

MEDP REN Denied

MEDP Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire? N

MEDP REN Investigation

MEDP Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate? N

MEDP REN Abuse, chemical substance

MEDP Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol? N

MEDP REN Impaired Ability

MEDP Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine? N

MEDP REN Felony

MEDP Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court? N

MEDP REN National Data Bank

MEDP Have you been reported to the National Practitioner's Data Bank? If yes, please attach a copy of the report. N

MEDP REN Investigation

MEDP Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine. N

MEDP REN Suspended

MEDP Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave? N

MEDP REN Malpractice

MEDP Have any medical malpractice claims been made against you? N

MEDP REN Other location

MEDP Are you practicing in any other location other than the principal business address listed on this renewal? If so, please attach a list with all additional business address(es) and business phone number(s). Y

MEDP REN NH Prescription Drug Monitoring

MEDP Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)? Y

MEDP SSN

MED P The Board will deny licensure if you refuse to submit your social security number (SSN). Your professional license will not display your SSN. Your SSN will not be made available to the public. The Board is required to obtain your SSN for the purpose of child support enforcement and in compliance with RSA 161-B:11. This collection of your SSN is mandatory. Last four digits of your Social Security Number: [redacted]

MEDP Attestation

MEDP I HEREBY CERTIFY UNDER PENTALTY OF UNSWORN FALSIFICATION THAT ALL INFORMATION IN THIS APPLICATION IS CURRENTLY ACCURATE. I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine. Y

MEDP REN Actively Practicing

MEDP Are you actively practicing medicine in NH?