Taylor, Penny

From: Taylor, Penny
Sent: Monday, April 8, 2019 11:47 AM
To: 'Debra L. Birenbaum'
Cc: Mary West
Subject: RE:

Dear Dr. Birenbaum:

The New Hampshire Board of Medicine ("Board"), at its April 3, 2019 meeting, approved an extension to **February 28, 2019** to complete your required continuing medical education ("CME") for the reporting period of January 1, 2017 through December 31, 2018. Unless you have already reported your CMEs, you must report 100 hours of approved continuing medical education; 40 hours of Category I and no more than 60 hours of Category II on or before **April 30, 2019** to the NH Medical Society, 7 North State Street, Concord, NH 03301. Please be advised that any CME's obtained in 2019 and used for the 2017-2018 reporting cycle may not be used for your 2019-2020 reporting cycle.

Please feel free to contact me at (603) 271-1205 if you have any questions.

Sincerely,

Penny Taylor, Administrator
Office of Professional Licensure and Certification
NH Board of Medicine
121 South Fruit Street, Suite 301, Concord, NH 03301-2412
Tel: (603) 271-1205 | Website: https://www.oplc.nh.gov/medicine

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From: Debra L. Birenbaum [redacted]
Sent: Wednesday, March 13, 2019 10:05 AM
To: Taylor, Penny
Subject:

I am writing to request an extension for the CME requirements, as I mistakenly did not complete the opiod requirements in a timely manner. I did an additional 2 CME hours during the week of Feb 11 2019 to complete the requirement. I was in touch with Mary West and she has not gotten to my application yet.
Thank you for your consideration of this, Debbie Birenbaum, license #8151

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

HEALTH & WELFARE BUILDING — HAZEN DRIVE

CONCORD, NEW HAMPSHIRE 03301

TEL. (603) 271-1203

July 12, 1989

Debra L. Birenbaum, M.D.
[redacted]

Dear Dr. Birenbaum:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license number 8151 is dated July 12, 1989.

Licensure is issued under the provisions of RSA 329:16 which states in part, " licenses issued under this section shall be conditioned upon the recipient taking up actual practice of medicine in the state within 18 months after issuance of the license and continuing such practice for at least one year....".

As soon as your engrossed certificate is received in this office, which should take approximately one year, it will be forwarded to you. Until such time, this letter is your full authorization for the privilege of practicing medicine in this state.

Sincerely,

Douglas M. Black

Douglas M. Black, M.D.
Vice President

DMB:pt
Enc.

Plans: Hitchcock Clinic
Spec: OB/GYN

The State of New Hampshire
Board of Registration in Medicine

Application No. 8956

I hereby apply* for license to practice Medicine in the State of New Hampshire as a Doctor of Medicine [~~as a Doctor of Osteopathy~~] ** and submit the following proofs, as required by the rules and regulations, formulated in accordance with the laws of the State of New Hampshire, and enclose a certified check or postal or express money order for the regular fee of $150.00 (U. S. Funds) No Refunds.

1. Personal Particulars

Name in full DEBRA LYNN BIRENBAUM
(Do not use initials) First Middle name

Present residence: No. [redacted], [redacted] Street, [redacted]
(City or town) (County) (State) Zip Code

Post office address .....

Date of birth [redacted] Birthplace [redacted]
(City town or county) (State or foreign country)

If foreign born, date and place of naturalization as a citizen of the United States: Date .....

..... Place .....

Age at last birthday [redacted] Sex F Single, Married, Widowed, or Divorced (*write the word*) [redacted] Color or race [redacted]

2. Academic Education:

Name and Location of Institutions attended.	Period of Study
UNIVERSITY OF PA. PHILADELPHIA PA	9/74 - 6/78

Academic degree of BA, received from UNIV OF PENNSYLVANIA 1978

3. Medical Education:

Name and Location of All Institutions attended.	Years attended with Date
TEMPLE UNIV SCHOOL OF MEDICINE	9/78 - 5/82

Degree of Doctor of Medicine [Osteopathy] received from TEMPLE UNIVERSITY

at PHILADELPHIA PA 1982

Period and places of practice ST LOUIS MO 4/87 - 7/88

SYRACUSE NY 7/88 - 6/89

Examined and licensed in the States of MICHIGAN, MISSOURI, NEW YORK
(Name all states in which ~~examined or~~ licensed)

4. Certificate of Medical Education‡:

It is hereby certified that ..... of .....

matriculated in ..... at .....
(Name of institution) (place)

on ..... 19 ....., attended ..... courses of lectures, and

on ..... 19 ..... received a diploma from this institution conferring the degree of Doctor of Medicine [Osteopathy].

.....
President, Secretary or Dean. [SEAL]

The seal of the institution must be affixed.

*This form is to be used for applicants for examination and for applicants for registration without examination.

**In filling out this blank indicate clearly whether the application is for a doctor of medicine or doctor of osteopathy by striking out the appropriate words as indicated herein.

‡ The Board may at its discretion require a slip or leaf from Prospectus of College or School showing what preliminary education is required to enter, and what medical study and standard are required for graduation.

***5. Certified Copy of State or National Board License or Certificate.**

(Give a verbatim copy of License or Certificate certified by the Secretary with seal.)

I hereby certify that the above is a true copy of certificate or license No. ..... issued ..... A. D. .....

[SEAL] .....
Secretary.

The seal of the board must be affixed

6. Affidavit of Secretary.

STATE OF .....

County of ..... ss.

.....of .....

being duly sworn, says that he is Secretary of .....

.....and that the original of the preceding certified copy of State or National Board License or Certificate No. ..... was issued to Dr. .....

.....

of ..... on ..... 1 .....

after a written examination by this Board in the following branches and upon obtaining a rating averaging ..... per cent .....

.....

.....

.....

.....

.....

.....

.....

The subjects of examination and rating of each must be stated in full

..... M. D. [D. O.], Secretary.

Sworn to before me this ..... day of ..... 19.....

..... Notary Public. [SEAL]

*If used for examination application items 5 and 6 do not need to be executed.

9. Affidavit of Registrar

STATE OF .....

County of ..... ss.

..... being

duly sworn says that he is the ..... of the Town (of the Village,
(title of official executing this affidavit)

City, County, Registration District, Province, State) of .....

and custodian of the records of birth thereof, and that an official record of birth bearing the name of

..... born
(give name exactly as it appears on the record)

on ....., 1....., at Number ..... Street in
(month) (day)

the Town / City of ..... County of..... State of .....,

child of .....
(name of father exactly as it appears on the record)

and ..... is on file in the office of said official, and further that it
(name of mother exactly as it appears on the record)

appears that said official record of birth was filed on ....., 1.....
(month) (day)

(Signature) .....

Sworn to before me this ..... day of ..... 19.....

..... (SEAL)

Notary Public

10. Affidavit of Physician.

STATE OF .....

County of ..... ss.

I, ... M. D. [D. O.] of .....

being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for ..... years; that I hold license No. ..... to practice medicine [osteopathy] in the State [Province] of .....; and that I know applicant personally to be a physician [osteopathic physician] of good moral character and in good professional standing.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

11. Affidavit of Physician.

STATE OF .....

County of ..... ss.

I, ... M. D. [D. O.] of .....

being duly sworn do hereby certify: that I am acquainted with applicant and have known him (her) for ..... years; that I hold license No. ..... to practice medicine [osteopathy] in the State [Province] of .....; and that I know applicant personally to be a physician [osteopathic physician] of good moral character and in good professional standing.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

12. Affidavit of Officer of Medical [Osteopathic] Society:

STATE OF .....

County of ..... ss.

..... M. D. [D. O.] of .....

being duly sworn, says that he is President or Secretary of the .....

Medical [Osteopathic] Society, and that ..... M. D. [D. O.] of

..... is at present a member in good standing of the said Medical [Osteopathic] Society and that he is an ethical practitioner of good moral character.

..... M. D. [D. O.]

Sworn to before me this ..... day of ..... 19.....

[SEAL] ..... Notary Public.

13. Affidavit of the Applicant:

STATE OF NEW YORK

County of [redacted] ..... ss.

DEBRA LYNN BIRENBAUM ..... of [redacted]

being duly sworn says that she is the person referred to in the above application for a license to practice medicine as a Doctor of Medicine [as a Doctor of Osteopathy] in the State of New Hampshire; that he is a citizen of the United States [of Canada in the province of .....

.....] as shown by the above Affidavit of Registrar, wherein his name appears as

..... DEBRA L. BIRENBAUM .....

[or proof of citizenship ..... hereto attached]; that he has studied the treatment of human ailments not less than four school years prior to receiving the degree of Doctor of Medicine [Osteopathy]; that all the statements herein contained respecting age, citizenship, residence, academic and medical education, internship, state or national board examination and license, good professional standing, and any other statements made on said application or attached hereto are each and all true in every respect, and that no disciplinary action has been brought against him by any State, county or local medical society.

He further says that he has never been an inmate in an institution for treatment for insanity, drug addiction, or inebriety, except as follows: .....; and that he has never been convicted, nor fined, nor imprisoned, nor placed on probation, nor has he ever forfeited collateral for breach or violation of any law or police regulation or ordinance whatsoever except as follows: .....

.....

.....

Debra L. Birenbaum ..... M. D. ~~[D. O.]~~

Sworn to before me this 9th day of June 1989

[SEAL] Joanne M. Halton ..... Notary Public.

JOANNE M. HALTON
Notary Public in the State of New York
Qualified in Onondaga County No. 1647000
My Commission Expires May 31, 1991

7. Affidavit of Internship.

STATE OF ..... [SEAL]

County of ..... ss.

..... being duly sworn, says that he is

..... of the ..... Hospital located

at ..... and that .....

..... M. D. [D. O.], has been an intern at said hospital at least

12 months from ..... 19..... to ..... 19.....

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

....., M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public.

(affix seal above line)

8. Affidavit of
Internship
Residency

STATE OF .....

County of ..... ss.

..... being duly sworn, says that he is

..... of the ..... Hospital located

at ..... and that .....

..... M. D. [D. O.], has been an $\frac{\text{intern}}{\text{resident}}$ at said hospital from

..... 19..... to ..... 19.....

Type of service (straight or rotating)
Division of service (medical, surgical, etc.)
If rotating, specify (in months) time devoted to:

Medicine	Dermatology	Pathology
Surgery	Oto-laryngo-rhinology	Neurology
Obstetrics	Ophthalmology	Clinical laboratory
Gynecology	Roentgenology	
Pediatrics	Psychiatry	

..... M. D. [D. O.]
(Medical Director) (Chief of Staff)

Sworn to before me this ..... day of ..... 19 .....

..... Notary Public. [SEAL]

THE STATE OF NEW HAMPSHIRE
BOARD OF REGISTRATION IN MEDICINE

(the following is to be filled out by the board)

Application received 6/12 19 89

Application examined ..... 19.....

Candidate interviewed 5-8 19 89

by Dr. Howard Rawnsley

Fee paid 6/12 19 89

Application approved [denied] ..... 19.....

Examination ..... 19.....

Accepted without examination ..... 19.....

License granted .....

Date 7-12 19 89

License No. 8151

Form of fee	P.O. order	Check	Cash	Express Order	Other
		150			

Remarks: .....

Applicant Please do not write above this line

The affixed photograph is of

Debra L. Brenlaum

(Signature of Applicant)

SOCIAL SECURITY #: [redacted]

CURRICULUM VITAE

DEBRA L. BIRENBAUM, M.D.

Date of Birth: [redacted]

Place of Birth:

Home Address:

Professional Address:
Crouse Irving Memorial Hospital
Department of Obstetrics and Gynecology
3 West Tower
736 Irving Avenue
Syracuse, New York 13210
(315)-470-7900

Social Security Number: [redacted]

Education:

Bachelor of Arts - History
University of Pennsylvania
College of Arts and Science
Graduation with Distinction 1974-1978

Doctor or Medicine
Temple University
School of Medicine 1978-1982

Postgraduate Training:
University of Michigan Medical Center
Department of Obstetrics and Gynecology
July 1982 - June 1986

Certification and Licensure:

Diplomate
National Board of Medical Examiners, 1983
American Board of Obstetrics and Gynecology,
Part 1, June 1986

Michigan	#48037	1984
Missouri	#R2G68	1986
New York	#174219-1	1988

Professional Society Membership:

Michigan State Medical Society
Washtenaw County OB/GYN Society
Junior Fellow - American College of Obstetrics and Gynecology
Norman F. Miller Gynecologic Society
St. Louis OB/GYN Society

Employment:

Attending Physician, Labor and Delivery
St. Louis Regional Medical Center
5535 Delmar Boulevard
St. Louis, Missouri 63112
March 1987 - June 30, 1987

Instructor
Department of Obstetrics and Gynecology
Washington University
School of Medicine
4911 Barnes Hospital Plaza
St. Louis, Missouri 63110
July 1, 1987 - June 30, 1988

Pelvic Surgery Fellow
State University of New York
Health Science Center at Syracuse
Crouse Irving Memorial Hospital
736 Irving Avenue
Syracuse, New York 13210
July 1, 1988 - present

Publications:

Ayers JW, Birenbaum DL, Menon KM. Luteal Phase Dysfunction in Endometriosis: Elevated progesterone levels in peripheral and ovarian veins during the follicular phase. FERT STERIL 1987 June 47(6) 925-9.

CURRICULUM VITAE

DEBRA L. BIRENBAUM, M.D.

Date of Birth:

Place of Birth:

Home Address:

[redacted]

Professional Address: Crouse Irving Memorial Hospital
Department of Obstetrics and Gynecology
3 West Tower
736 Irving Avenue
Syracuse, New York 13210
(315)-470-7900

Social Security Number: [redacted]

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Doctor of Medicine
Temple University
School of Medicine 1978-1982

Postgraduate Training: University of Michigan Medical Center
Department of Obstetrics and Gynecology
July 1982 - June 1986

Certification and Licensure:

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4911 Barnes Hospital Plaza
St. Louis, Missouri 63110
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Pelvic Surgery Fellow
State University of New York
Health Science Center at Syracuse
Crouse Irving Memorial Hospital
736 Irving Avenue
Syracuse, New York 13210
July 1, 1988 - present

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TEMPLE · UNIVERSITY

OF · THE · COMMONWEALTH · SYSTEM · OF · HIGHER · EDUCATION

BY · AUTHORITY · OF · THE · BOARD · OF · TRUSTEES · AND · UPON · RECOMMENDATION OF · THE · FACULTY · HEREBY · CONFERS · UPON

Debra Lynn Birenbaum

THE · DEGREE · OF

Doctor of Medicine

THIS IS A TRUE AND CORRECT COPY OF THE ORIGINAL

Joanne M. Halton

JOANNE M. HALTON
Notary Public in the State of New York
Qualified in Onondaga County No. 1647000
My Commission Expires May 31, 19[illegible]

TOGETHER · WITH · ALL · THE · RIGHTS · PRIVILEGES · AND · HONORS · APPERTAINING THERETO · IN · RECOGNITION · OF · THE · SATISFACTORY · COMPLETION OF · THE · COURSE · PRESCRIBED · BY · THE · FACULTY · OF · THE · UNIVERSITY

IN · TESTIMONY · WHEREOF · THE · UNDERSIGNED · HAVE · SUBSCRIBED THEIR · NAMES · AND · AFFIXED · THE · SEAL · OF · THE · UNIVERSITY

GIVEN · AT · PHILADELPHIA · PENNSYLVANIA · ON · THIS · TWENTY-SEVENTH · DAY OF · MAY · NINETEEN · HUNDRED · AND · EIGHTY-TWO

J. Eugene Dixon
CHAIRMAN · OF · THE · BOARD · OF · TRUSTEES

Marvin Wachman
PRESIDENT · OF · THE · UNIVERSITY

George H. Hagarin
SECRETARY · OF · THE · UNIVERSITY

Leon Jaroff MD
DEAN

The University of Michigan Hospitals

This is to certify that

Debra L. Birenbaum, M.D.

has served as a

House Officer I, II, III, IV

in the

Department of Obstetrics and Gynecology

from July 1, 1982 to June 30, 1986

THIS IS A TRUE AND CORRECT
COPY OF THE ORIGINAL

Joanne M Halton

JOANNE M. HALTON
Notary Public in the State of New York
Qualified in Onondaga County No. 1647000
My Commission Expires May 31, 19 91

Joyce E Munson

Dean, Medical School

THE UNIVERSITY OF MICHIGAN
ARTIS SCIENTIA VERITAS
1817

Professor and Chairman
Department of Obstetrics and Gynecology

Executive Director, University Hospitals

State of New Hampshire

BOARD OF REGISTRATION IN MEDICINE

HEALTH & WELFARE BUILDING — HAZEN DRIVE

CONCORD, NEW HAMPSHIRE 03301

TEL. (603) [redacted]
271-1203

NEW HAMPSHIRE BOARD OF REGISTRATION IN MEDICINE

SUPPLEMENT TO APPLICATION FOR FULL LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: DEBRA L. BIRENBAUM

PERMANENT ADDRESS: _____

LOCAL MAILING: _____

ADDRESS IN (NH): _____

HOSPITAL: DARTMOUTH HITCHCOCK MEDICAL CENTER

ADDRESS: 2 MAYNARD ST
HANOVER, NH 03756
(effective 9/1/89)

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? If So How Many _____?	___	✓
2. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	___	✓
3. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	___	✓
4. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination or failed to gain certification from the National Board of Medical Examiners?	___	✓

		YES	NO
5.	Have you ever failed a foreign licensing or certification examination?	___	✓
6.	Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	✓
7.	Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	___	✓
8.	Are any formal disciplinary charges pending or has any 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)?	___	✓
9.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?	___	✓
10.	Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	___	✓
11.	Have you ever, for any reason, lost American Specialty Board Certification?	___	✓
12.	Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?_____ _____	___	✓
13.	Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	___	✓
14.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	___	✓
15.	Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	___	✓

		YES	NO
16.	Are you now, or have you been in the past, dependent upon alcohol or drugs?	___	✓
17.	Have you ever held a license in New Hampshire or any other state or country? If yes, list other juridsictions. MICHIGAN . MISSOURI . NEW YORK .	___	___

NOTE ON QUESTIONS 14-16: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #17 please explain on the reverse side. Attach additional 8 1/2" X 11" sheets if necessary.

To the best of my knowledge I meet the qualifications for Full Licensure in New Hampshire.

I hereby certify under the penalty of perjury that all information on this form including attached sheets is true.

NAME (PLEASE PRINT) DEBRA L. BIRENBAUM

SIGNATURE: Debra L. Birenbaum DATE 6/25/89

1/4/88
NEWFORM

[redacted] 4, 1992

Private _____ Other (Specify) Group Retired? _____

ARE YOU CERTIFIED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES? Yes

✓ YES ____ NO IF YES, DESIGNATE SPECIALTY OB/Gyn

SOCIAL SECURITY NUMBER [redacted]

_____ I do not intend to renew by license - please place my license on inactive.

$75.00 DUE AND PAYABLE PRIOR TO JUNE 30, 1992.

$75.00 RENEWAL FEE + $75.00 LATE FEE FOR ALL RENEWAL CARDS RECEIVED AFTER JULY 1, 1992.

MAKE CHECK PAYABLE TO: TREASURER, STATE OF NH

CHANGE OF ADDRESS

DEERA L BIRENBAUM MD
DARTMOUTH-HITCHCOCK
MEDICAL CENTER
LEBANON NH 03756

[redacted] LAST REGISTRATION PERIOD:

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION OR LIMITATION OR RESTRICTION, OR ANY AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD? ___ YES ✓ NO

2. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/ REVOCATION OF YOUR DEA? ___ YES ✓ NO

3. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE? ___ YES ✓ NO

4. HAVE YOU FAILED A WRITTEN (INCLUDING SPEX) OR ORAL EXAMINATION FOR LICENSURE OR COMPETENCY DETERMINATION? ___ YES ✓ NO

5. HAVE YOU BEEN HOSPITALIZED OR TREATED WITH MEDICATION FOR ANY PSYCHIATRIC, NEUROLOGICAL, OR COMMUNICABLE ILLNESS FOR A PERIOD EXCEEDING THIRTY DAYS? ___ YES ✓ NO

6. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR INVOLVING MORAL TURPITUDE? ___ YES ✓ NO

7. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? ___ YES ✓ NO

8. ARE YOU OR HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING, BY ANY HOSPITAL, PROFESSIONAL SOCIETY, OR OTHER HEALTH CARE FACILITY? ✓ ___ YES ___ NO

9. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR DENIED. ___ YES ✓ NO

IF THE ANSWER IS YES, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra C Brenham — 5/11/92

Signature of Licensee (Signature Stamp Not Accepted) — Date

LIST ALL HOSPITAL AFFILIATIONS: Dartmouth Hitchcock Medical Center

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

JUN 1 8 1993

EXPIRES: 06/30/1994

DEBRA L BIRENBAUM MD
DARTMOUTH-HITCHCOCK
MEDICAL CENTER
LEBANON NH 03756

Please check appropriate mailing address.

Name in full DEBRA L BIRENBAUM

✓ Place of employment Dartmouth Hitchcock Medical Center, Lebanon NH

Business Tel. 603-650-8370

Home Address [redacted]

Home Tel.

Practice? Private _____ Other (Specify) Group Retired? _____

Specialty OB gyn Board Certified? YES If yes, designate specialty OB gyn

Social Security # [redacted]

_____ I DO NOT intend to renew my license - please place my license on inactive status.

List all hospital affiliations: Fairmont + Hitchcock Medical Center

In what other states do you hold license: _____

1. HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ____ YES	✓ NO
2. HAVE YOU EVER BEEN DENIED OR YOU HAVE SURRENDERED A LICENSE IN ANY OTHER STATE?	2. ____ YES	✓ NO
3. HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OR YOUR DEA?	3. ____ YES	✓ NO
4. HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ____ YES	✓ NO
5. HAVE YOU FAILED A WRITTEN (INCLUDING SPEX) OR ORAL EXAMINATION OR LICENSURE OR COMPETENCY DETERMINATION?	5. ____ YES	✓ NO
6. HAVE YOU EVER HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	6. ____ YES	✓ NO
7. HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	7. ____ YES	✓ NO
8. HAVE YOU EVER BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK?	8. ____ YES	✓ NO
9. ARE YOU NOW OR HAVE YOU EVER BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	9. ____ YES	✓ NO
10. HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED OR LIMITED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE ANY PRIVILEGES BEEN DENIED OR SURRENDERED?	10. ____ YES	✓ NO
11. HAVE ANY MEDICAL MALPRACTICE CLAIMS EVER BEEN MADE AGAINST YOU?	11. ____ YES	✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L. Bruenlsum
Signature of Licensee (Signature Stamp Not Accepted)

6/2/93
Date

J.

MAY 23 1994

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

EXPIRES: 06/30/1995

Please check appropriate mailing address.

Name in full DEBRA LYNN BIRENBAUM

_____ Place of employment DHMC

LEBANON NH

Business Tel: 650-8370

DEBRA L BIRENBAUM MD
DARTMOUTH-HITCHCOCK MED CTR
1 MEDICAL CENTER DR
LEBANON NH 03756

_____ Home Address [redacted]

Home Tel: [redacted]

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

SPECIALTY OB GYN BOARD CERTIFIED? YES

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS. DHMC Lebanon NH

IN WHAT OTHER STATES DO YOU HOLD LICENSE: ___

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES ✓ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES ✓ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenbaum
Signature of Licensee (Signature Stamp Not Accepted)

5-11-94
Date

STATE OF NEW HAMPSHIRE

Board of Registration in Medicine

JUN 14 1995

EXPIRES: 06/30/1996
8151

DEBRA L BIRENBAUM MD
DARTMOUTH-HITCHCOCK MED CTR
1 MEDICAL CENTER DR
LEBANON NH 03756

Please check appropriate mailing address.

Name in full DEBRA L BIRENBAUM

✓ Place of employment DHMC
LEBANON NH 03756

Business Tel: 603-650-8147

____ Home Address [redacted]

Home Tel: [redacted]

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

SPECIALTY OB GYN BOARD CERTIFIED? YES

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: DHMC Lebanon NH

IN WHAT OTHER STATES DO YOU HOLD LICENSE: NONE

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES ✓ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES ✓ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brendamour — Signature of Licensee (Signature Stamp Not Accepted)

5-8-95 — Date

MAY 0 2 1996

STATE OF NEW HAMPSHIRE

Board of Medicine

8956

EXPIRES: 06/30/1997

Please check appropriate mailing address.

Name in full DEBRA L. BIRENBAUM

✓ Place of employment DHMC

Business Tel: 603-650-8147

Home Address [redacted]

Home Tel:

DEBRA L BIRENBAUM MD
DARTMOUTH-HITCHCOCK MED CTR
1 MEDICAL CENTER DR
LEBANON NH 03756

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

RENEWAL FEE: $100.00

SPECIALTY OB GYN BOARD CERTIFIED? YES

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: OHmc

IN WHAT OTHER STATES DO YOU HOLD LICENSE: NONE

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
2.	HAVE YOU BEEN DENIED OR HAVE YOU SURRENDERED A LICENSE IN ANY STATE OTHER THAN FOR RELOCATION OR RETIREMENT?	2. ___ YES ✓ NO
3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY, OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
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9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ___ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Deborah L Brendamm
Signature of Licensee (Signature Stamp Not Accepted)

4-10-96
Date

MAY 23 1997

STATE OF NEW HAMPSHIRE

8956

Board of Medicine

EXPIRES: 6/30/98

Please check appropriate mailing address.

Name in full DEBRA L BIRENBAUM

✓ Place of employment DHMC

Business Tel: 603-650-8161

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED CTR
1 MEDICAL CENTER DR
LEBANON NH 03756

____ Home Address [redacted]

Home Tel: [redacted]

HAVE YOU BEEN CONTINUOUSLY ENGAGED IN THE ACTIVE PRACTICE OF MEDICINE? YES ✓ NO ___ IF NO, PLEASE EXPLAIN

[redacted]

RENEWAL FEE: $100.00

SPECIALTY OB/GYN BOARD CERTIFIED? ___

___ I DO NOT INTEND TO RENEW MY LICENSE - PLEASE PLACE MY LICENSE ON INACTIVE STATUS.

LIST ALL HOSPITAL AFFILIATIONS: OHMC

IN WHAT OTHER STATES DO YOU HOLD LICENSE: —

IN THE PAST 12 MONTHS:

1.	HAS ANY ACTION, INCLUDING ANY DISCIPLINARY ACTION, LIMITATION, RESTRICTION, OR AN AGREEMENT FOR ANY REASON INCLUDING REHABILITATION BEEN TAKEN OR ENTERED BY A LICENSING BOARD?	1. ___ YES ✓ NO
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3.	HAS THERE BEEN ANY DENIAL, RESTRICTION, SUSPENSION OR LOSS/REVOCATION OF YOUR DEA?	3. ___ YES ✓ NO
4.	HAVE YOU BEEN TREATED FOR USE OR MISUSE OF ANY CHEMICAL SUBSTANCE?	4. ___ YES ✓ NO
5.	HAVE YOU HAD ANY EMOTIONAL DISTURBANCE OR MENTAL ILLNESS WHICH HAS IMPAIRED YOUR ABILITY TO PRACTICE MEDICINE?	5. ___ YES ✓ NO
6.	HAVE YOU BEEN FOUND GUILTY OR ENTERED A PLEA OF NO CONTEST TO ANY FELONY OR TO A MISDEMEANOR?	6. ___ YES ✓ NO
7.	HAVE YOU BEEN REPORTED TO THE NATIONAL PRACTITIONER DATA BANK? IF YES, PLEASE SUBMIT A COPY OF THE REPORT	7. ___ YES ✓ NO
8.	HAVE YOU BEEN THE SUBJECT OF AN INVESTIGATION OR DISCIPLINARY PROCEEDING?	8. ___ YES ___ NO
9.	HAVE ANY HOSPITAL PRIVILEGES BEEN SUSPENDED, LIMITED, OR DENIED OTHER THAN FOR MEDICAL RECORDS VIOLATIONS, OR HAVE YOU BEEN PLACED ON ADMINISTRATIVE LEAVE?	9. ___ YES ✓ NO
10.	HAVE ANY MEDICAL MALPRACTICE CLAIMS BEEN MADE AGAINST YOU? SEE ATTACHED REPORTING FORM	10. ___ YES ✓ NO

IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, PLEASE FILE A WRITTEN EXPLANATION.

I HEREBY CERTIFY, UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlamp
Signature of Licensee (Signature Stamp Not Accepted)

4-22-97
Date

JUN 0 8 1998

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/1999

Renewal Fee: $100.00

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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OB

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151

File #: 8956

☒ Work Address:

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

☐ Home Address:

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
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 or misdemeanor?	___	✓
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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlan
Signature of Licensee (Signature Stamp Not Accepted)

5-22-98
Date

JUN 0 2 1999

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2000

Renewal Fee: $100.00

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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151 ☑

File #: 8956 ☐

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756
Phone: 603*650-~~8370~~
8164

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
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 or misdemeanor?	___	✓
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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlo
Signature of Licensee (Signature Stamp Not Accepted)

5/4/99
Date

MAY 3 1 2000

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 6/30/2001 Renewal Fee: $100.00

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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151 File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756
Phone: 603*650-8164

☐ Home Address

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER- LEBANON, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
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 or misdemeanor?	___	✓
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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlan
Signature of Licensee (Signature Stamp Not Accepted)

5/18/20
Date

APR 2 5 2001

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520 ck# 510403.

RENEWAL APPLICATION

For expiration on: (date) 10/30/2002 Renewal Fee: $150.00

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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151

File #: 8956

☒

Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756
Phone: 603*650-8164

☐

Home Address

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER- LEBANON, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	√
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	√
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	√
4. Have you been treated for use or misuse of any chemical substance?	___	√
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 or misdemeanor?	___	√
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?	___	√
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.	___	√

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlan
Signature of Licensee (Signature Stamp Not Accepted)

4/2/01
Date

APR 1 0 2002

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

#15158

RENEWAL APPLICATION

For expiration on: 6/30/2003

Renewal Fee: $150.00

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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151

File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603*650-8164

☐ Home Address

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located.)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER- LEBANON, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
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 or misdemeanor?	___	✓
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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenkamm
Signature of Licensee (Signature Stamp Not Accepted)

3/25/02
Date

MAY 14 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

#113089

For expiration on: 06/30/05

Renewal Fee: $300.00
of 900.00

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

If you choose not to renew, your license will be place on inactive status. To reactive 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 address within 30 days of the change.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

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

License #: 8151

File #: 8956

☒ Work Address

☐ Home Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603*650-8164

[redacted]

Hospital Affiliations: **(If not a NH hospital, please list city and state where hospital is located)**

DARTMOUTH-HITCHCOCK MEDICAL CENTER- LEBANON, NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician 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 or misdemeanor?	___	✓
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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenda
Signature of Licensee (Signature Stamp Not Accepted)

5/1/03
Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934 JUN 0 1 2005

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

#174222
$600.00

RENEWAL APPLICATION

For expiration on: 06/30/07

Renewal Fee: $300.00

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

If you choose not to renew, your license will be place 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 address within 30 days of the change**.

Specialty: OBG

Board Certified: (Y/N) Y
Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.)

NONE

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

License #: 8151

File #: 8956

☐ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

653-9312
Phone: 603*~~650-8164~~
Business Fax Number:
Business Email Address:

☐ Home Address

[redacted]

[redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCOC	LEBANON	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician 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 or misdemeanor 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?	___	✓
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.	___	✓

I HEREBY CERTIFY UNDER PENALTY OF PERJURY, THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Debra L Brenlann
Signature of Licensee (Signature Stamp Not Accepted)

5/13/05
Date

MAY 30 2007

RECEIVED

STATE OF NEW HAMPSHIRE

BOARD OF MEDICINE MAY 29 2007

2 Industrial Park Drive, Suite 8

Telephone #: 603-271-6934

Concord, NH 03301-8520 NH BOARD

3484

RENEWAL APPLICATION

For expiration on: 06/30/2009

Renewal Fee: $300.00

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 address within 30 days of the change**.

Specialty: OBG

Board Certified: (Y/N) Y

Please list ABMS Board Specialty: OBG

Licensed in the states of: (2 letter state abbrev.) NONE

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

License #: 8151

File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603*653-9312
Business Fax Number: [redacted]
Business Email Address:

☐ Home Address

[redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH		☑	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician 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 or misdemeanor 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? 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.	___	✓

****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.

Debra Bond
Signature of Licensee (Signature Stamp Not Accepted)

5/18/07
Date

MAY 15 2009 RECEIVED
MAY 13 2009
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2011

Renewal Fee: $300.00

#492247
1 of 9

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 address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y/N) Y OBG
Please list ABMS Board Specialty: _____

Currently licensed in the states of: (2 letter state abbrev.) NONE

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 8151

File #: 8956

☑ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603*653-9312
Business Fax Number: [redacted]
Business Email Address:

☐ Home Address

Phone [redacted]

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

Hospital			Privilege Full	Courtesy	Consult
DARTMOUTH-HITCHCO	LEBANON	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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:	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, or have you surrendered or allowed to lapse, a license to practice medicine 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 Physician 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.	___	✓

****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.

Debra L Brenton — Signature of Licensee (Signature Stamp Not Accepted)

4/17/09 — Date

MAR 10 2011 RECEIVED

STATE OF NEW HAMPSHIRE

MAY 06 2011

Telephone #: 603-271-6934

NH BOARD

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee: $300.00

For Office Use Only: Date Pd: 5-6-11 Check # 574371

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 address within 30 days of the change.**

Specialty: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NONE

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 8151

File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603*653-9312
Business Fax Number: [redacted]
Business Email Address:

☐ Home Address

Phon[redacted]

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

Hospital			Privilege Full	Courtesy	Consult
DARTMOUTH-HITCHCOC	LEBANON	NH	☑	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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:	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, or have you surrendered or allowed to lapse, a license to practice medicine 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 Physician 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.	___	✓

****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 New Hampshire Board of Medicine.**

Debra L Brenton — 4/5/11

Signature of Licensee (Signature Stamp Not Accepted) — Date

MAY 08 2013

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

BOARD OF MEDICINE
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RECEIVED
APR 29 2013
NH BOARD

RENEWAL APPLICATION

Renewal Fee: $350.00

For Office Use Only: Date Pd: 4/29/13 Check # 5535

For expiration on: 6/30/2015

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 address within 30 days of the change.**

Specialty: OBG

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

Currently licensed in the states of: (2 letter state abbrev.) NONE

You must provide both home and business street address. PO Boxes are not acceptable.
Please mark the box next to the address you would prefer to list as your mailing address.

License #: 8151

File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*653-~~9312~~ 9384

Phone: 802-649-3249

Business Fax Number: [redacted]

Business Email Address: [redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
DARTMOUTH-HITCHCOC	LEBANON	NH		☑	☐	☐
				■	■	■
				■	■	■
				■	■	■
				■	■	■
				■	■	■
				■	■	■

(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, or have you surrendered or allowed to lapse, a license to practice medicine 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 Physician 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.		✓

****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 New Hampshire Board of Medicine.**

Deborah L Berk — Signature of Licensee (Signature Stamp Not Accepted)

4/25/13 — Date

ABMS MOC℠ Certification Matters™

You are logged in as: Sharon.Canney@nh.gov Change Profile Sign out

Enter the doctor's information below or you can search by location and specialty. If you are unsure of any of the fields, leave it blank.

Last Name	birenbaum	First Name	debra
City		State/Province	[Select]
Zip Code		Specialty	[Select]

SEARCH CLEAR

View Search FAQs

Back To Results

Physician Certification

Name
Debra L. Birenbaum

Education
MD

Location (First city and state listed is the last known location)
[redacted]

Certification (For a definition of a specialty or subspecialty click here)
American Board of Obstetrics & Gynecology
Obstetrics & Gynecology - General (General indicates Primary Certificate)

Meeting Maintenance of Certification (MOC) Requirements
American Board of Obstetrics & Gynecology (Learn more about Meeting Board's MOC Requirements)
Obstetrics & Gynecology Yes

For some ABMS Member Boards, physicians who achieved Board Certification before those Boards established their MOC programs are

JUN 11 2015

RECEIVED

JUN 05 2015

NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 6/30/2017

Renewal Fee: $350.00

For Office Use Only: Date Pd: 6/8/15 Check # 6173

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: OBG

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

Currently licensed in the states of: (2 letter state abbrev.) NONE

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 #: 8151

File #: 8956

☒ Work Address
DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

☐ Home Address
[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*653-9384
Business Fax Number: [redacted]
Business Email Address: [redacted]

Hospital Affiliations: ***Please list city and state where [redacted] Check all type of **privileges you hold for each hospital.**

Hospital Privileges			Full	Courtesy	Consult	Other
DARTMOUTH-HITCHCO	LEBANON	NH	☑	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

(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).	___	✓
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)? ✓	error NB	✓
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.**

Debra L Beem — Signature of Licensee (Signature Stamp Not Accepted)

6/3/15 — Date

RECEIVED
JUN 05 2017
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2410

RENEWAL APPLICATION

For expiration on: 6/30/2019

Renewal Fee: $350.00

For Office Use Only: Date Pd: 6/7/17 Check #6704

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: OBG

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

Currently licensed in the states of: (2 letter state abbrev.) ~~NONE~~ NH

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 #: 8151

File #: 8956

☒ Work Address

DEBRA L BIRENBAUM, MD
DARTMOUTH-HITCHCOCK MED
1 MEDICAL CENTER DR
LEBANON, NH 03756

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*653-9384

Phone: [redacted]

Business Fax Number: [redacted]

Business Email Address:

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

Hospital Privileges

DARTMOUTH-HITCHCOCK MEDICAL CENTER	LEBANON	NH

(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 Expiration Date: 7/31/18	✓	

****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.**

Debra L Brenke
Signature of Licensee (Signature Stamp Not Accepted)

6/1/17
Date