File # 17287

Here is a copy of my marriage license for my name change. Please send me a new card with my new name.

Thank you,

Jillian (LeClair) Dulac

[redacted]

RECEIVED
OCT 28 2013
NH BOARD

License #:
16077
Ex 6/30/15

New License
Mailed 6/30/13
SA

TO: NH Board of Medicine

FROM: Jillian LeClair

Re: change of address as of June 1, 2013

Return Phone #: [redacted]

Total # of pages: 2

File # 17287

MARK SULLIVAN, P.A.
President

JOHN H. WHEELER, D.O.
Vice President of the Board

KATHRYN M. BRADLEY
Executive Director

PENNY TAYLOR
Administrator

ROBERT P. CERVENKA, M.D.
Vice President of the Medical Review Subcommittee
AMY FEITELSON, M.D.
ROBERT J. ANDELMAN, M.D.
ROBERT M. VIDAVER, M.D.
LOUIS E. ROSENTHALL, M.D.
MICHAEL BARR, M.D.
GAIL A. BARBA, PUBLIC MEMBER
DANIEL MORRISSEY, O.P., PUBLIC MEMBER
EDMUND J. WATERS, JR., PUBLIC MEMBER

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: Jillian Leclair Lic 16077

Business Name: Manchester OB-Gyn Associates

☒ Address: 150 Tarrytown Road

Manchester, NH 03103

Office telephone: (603) 622-3162

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

☐ Home Address: [redacted]

Home telephone [redacted]

Specialty: OB-Gyn Board certified: sitting for exam on 6/24/13

Hospital affiliations: Elliot Hospital

In what other states do you hold a current license: ϕ

As of June 1st, 2013 my home address will be:

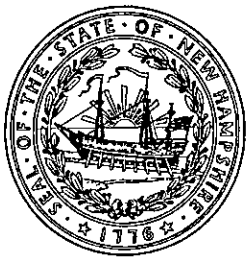
[redacted]

MARK SULLIVAN, P.A.
President

JOHN H. WHEELER, D.O.
Vice President of the Board

KATHRYN M. BRADLEY
Executive Director

PENNY TAYLOR
Administrator



ROBERT P. CERVENKA, M.D.
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Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

April 3, 2013

JILLIAN K LECLAIR MD
[redacted]

Dear Dr. Leclair:

Congratulations, the New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 16077 is dated April 3, 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.

08/GYN

Uniform Application for Physician Licensure

UA Username jillianleclair **Date Submitted** 1/14/2013
FCVS Status Applicant has an FCVS Packet

1/14/13

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.

1. Full Name (use no initials)

Last Name	LeClair
First Name	Jillian
Middle Name	Kathleen
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**
[ ] **Mailing**

Street 263 Farmington Ave
Dept OB/GYN

City Farmington **State/Province** CT **Zip Code** 06030
Country USA
Telephone (860)679-2853
Fax [redacted]
Email [redacted]
Alternate Phone

Home
[ ] **Public Access**
[X] **Mailing**

Street [redacted]

City [redacted] **State/Province** [redacted] **Zip Code** [redacted]
Country USA
Telephone [redacted]
Fax
Email [redacted]
Alternate Phone

LECLAIR, JILLIAN

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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]	[redacted]
Gender	Social Security Number	NPI	Are you a U.S. Citizen?

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	Dartmouth Medical School
Address	
City	Hanover
State/Province	NH
ZIP Code	03755-3833
Country	USA
Attendance Dates	**From (mm/yyyy)** 08/2005 **To (mm/yyyy)** 06/2009
Graduation Date	6/14/2009
Degree	MD

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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			

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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 University Of Connecticut
Hospital Address 270 Farmington Avenue
Suite 352

City Farmington
State/Province Connecticut
ZIP Code 06032
Country USA

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

Department/Specialty Obstetrics and Gynecology

From: 07 /2009 **To:** 06 /2013 **Successfully Completed?** ☐ **Yes** ☐ **No** **In Progress** ☒

Month Year Month Year

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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		06/2007	[X] P	[ ] F	1
USMLE Step 2		11/2008	[X] P	[ ] F	1
USMLE Step2 CS		11/2008	[X] P	[ ] F	1
USMLE Step 3		06/2010	[X] P	[ ] F	1

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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**	**Practitioner Type (MD, DO, etc.)**	**Type of License (Full, Temporary, etc.)**
	License Number	**Status**	**Issue Date**

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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: 2009 To: Month: Year: In Progress ☒	**Practice/Employment Name** University of Connecticut OB-GYN residency (or list non-working time as indicated above) **Practice/Employment Address** 242 S. Whitney St. Apt 1s **City** Hartford **State/Province** Connecticut **ZIP Code** 06105 **Country** USA **Position and Department** Resident-OB-GYN **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

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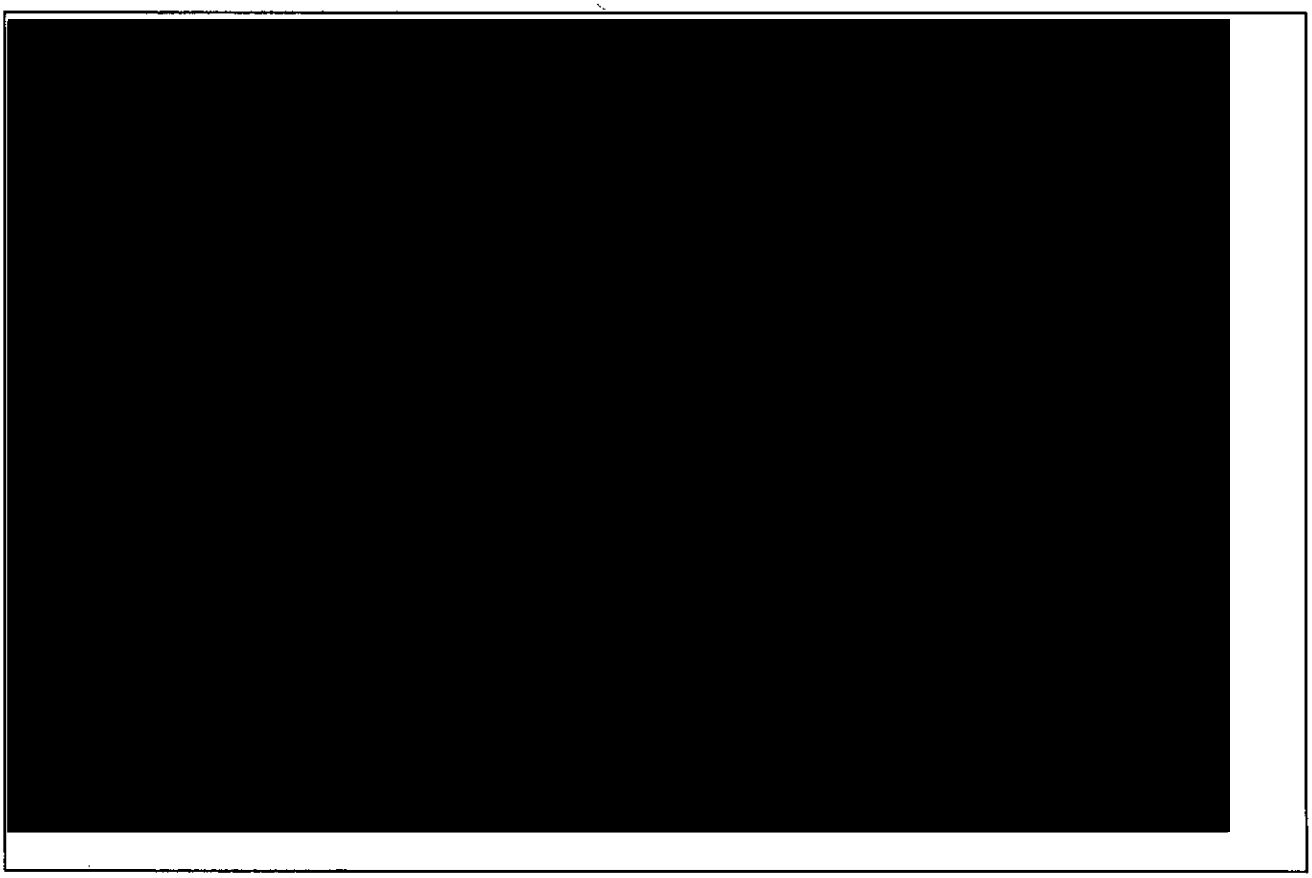
11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this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



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Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

RECEIVED
JAN 30 2013
NH BOARD

Affidavit
And
Authorization For Release of Information

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 Application for Physician 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.

Jillian LeClair
Applicant's Signature (must be signed in the presence of a notary)

LeClair
Applicant's Printed Last Name

Jillian K
Applicant's Printed First Name, Middle Initial, and Suffix (e.g., Jr.)

1/23/13
Date of Signature

NOTARY

Dated 1/23/13 Signed [signature]

State of CT County of Hartford

SUBSCRIBED AND SWORN TO before me this 23 day of, January 20 13.

My commission expires: 11/30/15 (NOTARY PUBLIC SIGNATURE & SEAL)

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ADDENDUM TO APPLICATION

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)?		✓

#1 – residency in OB-Gyn at the University of Connecticut

	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):

Manchester OB/Gyn Associates
150 Tarrytown Road
Manchester, NH 03103

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]

Applicant's Signature	Applicant's Printed Last Name	Date of Signature
[signature]	LeClair	1/8/13

For Board Use Only:

Application Received: 1/30, 2013 Fee Paid: $300 – Check#: 3412

License Number: _____ Date of Issue: _____

RECEIVED
JAN 30 2013
NH BOARD

Jillian K. LeClair
[redacted]

RESIDENCY

University of Connecticut, OB/Gyn: Farmington, CT — July 2009 - present

- Junior Fellow, American College of Obstetrics and Gynecologists
- Board eligible, American Board of Obstetrics & Gynecology

EDUCATION

Dartmouth Medical School: Hanover, NH — August 2005 – June 2009

- Doctor of Medicine, June 2009

College of the Holy Cross: Worcester, MA — August 2000 – May 2004

- Bachelor of Arts: biology/pre-med, biological psychology concentration
- GPA: 3.80/4.00, graduated magna cum laude, Phi Beta Kappa, dean's list every semester
- Charles Dana Scholarship Recipient

ROBOTICS

- Received extensive robotic training from attending physicians and DaVinci representatives
- Completed eight full robotic hysterectomies and portions of nineteen other cases
    - Assisted on eighteen robotic hysterectomies

AWARDS

- Arnold P. Gold Foundation's Humanism and Excellence in Teaching Award — June 2012
- Rebecca K. Lefcourt, M.D. Award for Academic Excellence — June 2012

RESEARCH

Research Assistant: Farmington, CT — January 2011 – May 2012

- Assisted Dr. Molly Brewer with a retrospective case series investigating the effect of cancer stems cells on survival, disease-free intervals, chemoresistance, and cytoreductive surgery

Research Assistant, Clinical Student: Augusta, ME and Concord, NH — June 2006 – August 2006

- Conducted research testing the hypothesis that the implementation of an electronic medical record would alter the amount of family history obtained in a primary care setting. Reviewed charts from the pre- and post-EMR periods for particular providers, in 3 separate offices.
- Interviewed and performed physical exams on patients with various preceptors, and also participated in 3rd year student didactic sessions.

Biological Psychology Research Student: Worcester, MA — September 2002 – May 2004

- Performed a literature review of journal articles pertaining to complementary and alternative medicine. Developed and administered two surveys to a random sampling of Holy Cross students.
- Presented a paper discussing the prevalence of complementary and alternative medicine use at Holy Cross. Discussed the differences in the reasoning capabilities between users and non-users.

PRESENTATIONS

Oral Presentation, 3rd Year Research Night: Farmington, CT — May 16, 2012

- "Cancer Stem Cells: Real Entity or Laboratory Phenomenon"

Oral Presentation, GYN Oncology Interest Group: Hartford, CT — October 19, 2011

- "Cancer Stem Cells: What are they?"
- Presented preliminary cancer cell research findings to a group of GYN oncologists

Oral Presentation, Northeast STFM Conference: Danvers, MA October 26, 2006

- "Family History and Electronic Medical Records in Primary Care"
- Presented findings illustrating a decrease in the occurrence of documented family history after the implementation of EMR charts (83% v. 51%) at MDFPR.

Gardiner Scholars Awards Ceremony Speaker: Gardiner, ME October 2003

WORK EXPERIENCE

Field Hockey Coach, Futures Site Director: Gardiner, ME August 2004 – May 2005

- Coached fundamental field hockey skills and tactics to high school student-athletes using fast-paced, challenging, and fun drills/games.
- Responsible for all club administrative functions and served as the liaison between Futures and the athletes.

Residency Applicant Guide, Research Assistant: Augusta, ME September 2004 – April 2005

- Led residency applicant orientation. Served as a guide for the applicants and spokesperson for the residency program. Acted as a liaison between the applicants and program administration.
- Researched existing hand-washing policies and identified areas of concern. Presented findings to hospital staff with suggestions for improving hand-washing compliance.
- Performed quality control analysis on an electronic medical records program. Compared the actual time-saving performance against claims made within the marketing literature from the software developer. Sanctioned by Maine-General to investigate performance at six individual clinics.

INTERESTS

RECEIVED
APR 08 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: 4/1/15 Check # 36677

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) N
(If yes, provide proof of board certification.)
Please list ABMS Board Specialty: _____

Currently licensed in the states of: (2 letter state abbrev.) 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 #: 16077

File #: 17287

☐ Home Address
JILLIAN K DULAC, MD
[redacted]

☒ Work Address
MANCHESTER OB-GYN ASSOCIA
150 TARRYTOWN ROAD
MANCHESTER, NH 03103

Please provide current Email, Fax and Phone Numbers below:

Phone: [redacted]

Phone: 603-622-3162
Business Fax Number: [redacted]
Business Email Address:

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
Elliot Hospital Manchester, NH	☒	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

XXX

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)?	✓	___
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)

Date 4/2/15

APR 20 2017

RECEIVED
APR - 4 2017
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: 4/4/17 Check # 39180

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) X Yes

(If yes, provide proof of board certification.)

Please list ABMS Board Specialty: OB/GYN

Currently licensed in the states of: (2 letter state abbrev.) 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 #: 16077

File #: 17287

☒ Work Address

JILLIAN K DULAC, MD
MANCHESTER OB-GYN ASSOCIA
150 TARRYTOWN ROAD
MANCHESTER, NH 03103

Phone: 603-622-3162
Business Fax Number: [redacted]
Business Email Address: [redacted]

☐ Home Address

[redacted]

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: [redacted]

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

Hospital Privileges

ELLIOT HOSPITAL	MANCHESTER	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: 6/30/2019	✓	

****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.**

[signature] 3/29/17

Signature of Licensee (Signature Stamp Not Accepted) Date

ACOG

THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

October 15, 2016

[redacted]
Jillian K. Dulac, MD
[redacted]

Dear Dr. Dulac:

It is my pleasure to congratulate you and welcome you as a Fellow of The American Congress of Obstetricians and Gynecologists and the American College of Obstetricians and Gynecologists! Your Fellow status is effective November 1, 2016, and you will be thereafter privileged to use the initials FACOG. A Certificate of Fellowship will be prepared and mailed to you, printed with your name as it appears above.

All Fellows admitted on November 1, 2016 will be formally inducted during the Convocation at the 2017 Annual Clinical and Scientific Meeting, May 6-9, 2017 in San Diego, CA. We invite you to participate in this important ceremony during which newly-inducted Fellows will be charged by ACOG's President, Dr. Thomas M. Gellhaus. Additional information will be forthcoming.

As a Fellow, you will receive *Obstetrics & Gynecology*, the official peer-reviewed journal of the College, *ACOG Rounds*, the newsletter of the Congress, and a variety of other publications. These publications will help you keep up-to-date with the latest developments in our profession. Visit the member side of our web site at www.acog.org to learn of the many other resources available to you.

The success of the Congress and the College depends on our ability to respond to the needs of Fellows. This is made possible, in part, by the extraordinary volunteer effort of Fellows who serve on committees and/or as officers at the section, district and national level. Your section and district chairs, as well as the staff of the national office, value your comments and contributions. We welcome you as a Fellow, and we encourage you to become an active Fellow and colleague.

Sincerely,

Hal C Lawrence MD

Hal C. Lawrence, III, MD, FACOG
Executive Vice President
Chief Executive Officer

HCL/ca
Enclosures

The American Congress of Obstetricians and Gynecologists
409 12th Street SW, Washington, DC 20024-2188
Mailing Address: PO Box 70620 Washington, DC 20024-9998
Telephone 202/638-5577 www.acog.org

ABO+G

American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

April 20, 2017

RE: Certification Status of Jillian Dulac, M.D.

To Whom It May Concern:

Jillian Dulac, M.D. is a Diplomate of the American Board of Obstetrics & Gynecology (ABOG).

Obstetrics and Gynecology Certification

ABOG ID Number: 9030109
Original Certification Date: 1/15/2016
Certification Status: Valid through: 12/31/2017
Participating in Maintenance of Certification: Yes

A physician becomes a Diplomate of the ABOG when he/she has fulfilled all requirements, has satisfactorily completed the written and oral examinations and has been awarded ABOG's certifying diploma.

Physicians certified by the ABOG in Basic Obstetrics and Gynecology prior to 1986 or subspecialty certified prior to November, 1987 hold non-time-limited (non-expiring) certificates. They are not required to participate in Maintenance of Certification.

Sincerely,

George D. Wendel, Jr. M.D.
Executive Director

A452469

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). N

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? Y