CYNTHIA S. COOPER, M.D.
President

WASSFY M. HANNA, M.D.
Vice President

BRUCE J. FRIEDMAN, M.D.
JAMES H. CLIFFORD, M.D.
JAMES G. SISE, M.D.
WILLIAM J. KASSLER, M.D., M.P.H.
KEVIN R. COSTIN, PA-C
MARY S. NELSON, PUBLIC MEMBER
JUDITH E. DICKINSON, 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.state.nh.us/medicine

May 7, 2003

BETSY S AUGUST MD

Dear Dr. August:

The Board of Medicine at its May 7, 2003 meeting reinstated your license to practice medicine in the State of New Hampshire. Your license number remains 10174 and is dated December 3, 1997.

Please keep this office informed of any change in home or office address.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

/pt
Encl.

RECEIVED
AUG 11 1997
NH BOARD OF MEDICINE

BROWN UNIVERSITY
Providence, Rhode Island 02912

June 11, 1997

To Whom It May Concern:

Re: Betsy Sue August

This is to certify that Betsy Sue August was awarded a Doctor of Medicine degree on May 28, 1984.

Charlotte A. Patten

Charlotte A. Patten
Associate Registrar

CAP/mp

OB GYN (BC)

RECEIVED
MAR 1 0 2003
NH BOARD

New Hampshire Board of Medicine

PHYSICIAN REINSTATEMENT APPLICATION

Staple your application fee of $200.00 to the upper left–hand corner of this page.

Name (as it will appear on your medical license): RECEIVED BY PHYSICIAN

AUGUST
Last Name (include Maiden Name, if applicable) Gen. Suffix

Betsy Sue
First Name Middle Name

Office Name: Feminist Health Center of Portsmouth

Office Address: 559 Portsmouth Ave., PO Box 456
Number and Street Apartment Number

Greenland, N.H. 03840
City State Zip (or postal) Code

Home Address (where all Board correspondence will be sent):

Number and Street Apartment Number

City State Zip (or postal) Code

Telephone Numbers

Business: (603) 436-7588 Home:

Other: Fax:

Identifying Information

Date of Birth: Month Day Year Place of Birth City State

Social Security Number: - -

For Board Use Only:

Application Received: 3-10, 2003 Fee Paid: 200.00 Check#:

License Number: Date of Issue:

7/2/02

Application for Licensure by Endorsement (continued)

RECEIVED BOARD OF PHYSICIAN

List all states where you hold or have ever held a license to practice medicine. **Please continue list on back of this page if needed.**

Ma.					

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. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates).	✓	
2. Have you ever, for any reason, lost American Specialty Board Certification?		✓
3. Have you been denied required recertification by any specialty boards? (If yes, list each boards and dates denied).		✓
4. 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).	✓	
5. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?		✓
6. 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?		✓
7. 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.)		✓
8. Have you ever failed a foreign licensing or certification examination?		✓
9. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		✓
10. 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?		✓
11. 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)?		✓

12. 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? ____ ✓

13. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors or felonies? ____ ✓

14. 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? ____ ✓

15. Have you ever had any physical, emotional or mental illness which has impaired or would be likely to impair your ability to practice medicine? ____ ✓

16. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such? ____ ✓

RECEIVED BY PHYSICIAN

Anticipated Practice Location(s) (if known):

Feminist Health Center of Portsmouth

I, Betsy August
(type/print your complete name)

hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or 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 enclosed a check or postal or express money order for the application fee of $200.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. In doing so, I hereby release, discharge, and hold harmless the State of New Hampshire, the Board of Medicine, its agents or representatives and any person furnishing information, records, or documents of any and all liability.

August	Betsy	Sue
Typed/Printed Last Name	First Name	Middle Name

Betsy August — 2/27/03
Applicant's Signature — Date of Signature

AFFIDAVIT OF THE APPLICANT

RECEIVED BY PHYSICIAN

STATE OF Massachusetts
(where applicant resides)

COUNTY OF ____
(where applicant resides)

I, Betsy August of ____
(Applicant's Name) (City and State where Applicant Resides)

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the State of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age and licenses, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Applicant's Photograph

ort photograph
ere.

Betsy Augustus
Applicant's Signature

AUGUST Betsy Sue
Last Name First Name Middle Name

2/20/03
Date of Signature

Sworn to before me this 20 day of February, 2003

Donna Coan
NOTARY PUBLIC
My commission expires Oct. 3, 2008

Donna M Coan
Notary Public signature

Date Commission Expires:

[Affix Seal Here]

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

bstetrics and ynecology

Betsy Sue August, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK,
HAS MET THE STANDARDS AND QUALIFICATIONS, AND PASSED THE EXAMINATIONS
REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC.,
AND IS AN ACKNOWLEDGED DIPLOMATE OF THE BOARD

FROM FEBRUARY, 2000 THROUGH DECEMBER, 2010
FEBRUARY 28, 2000

Gerson Weiss, President

N. Gant, M.D., Executive Director

Philip J. DiSaia
William Droegemueller
Ronald S. Gibbs
Robert C. Cefalo

Haywood L. Brown
Arthur L. DeCherney
Hamish? Dwyer
Sherman Elias
Wesley C. Fowler
Larry C. Gilstrap III

Michael J. Mennuti
Donald K. Rahhal

American Board of Obstetrics & Gynecology

DIPLOMATE NO. 884108

Donna Coan
NOTARY PUBLIC
My commission expires Oct.

National Board of Medical Examiners

of the.

RECEIVED BY PHYSICIAN

United States of America

Betsy S. August, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest Clu Daeschner, Jr.
Chairman of the Board

Edithe J. Levin
President of the Board

Philadelphia Pa
July 1, 1985

Certificate No.
274987

Donna L Coan
Feb 20, 2003

Donna Coan
NOTARY PUBLIC
My commission expires Oct. 3, 2008

Resume of

BETSY S. AUGUST, M.D., F.A.C.O.G.

RECEIVED BY PHYSICIAN

Home:
Office: (978) 741-3700

OVERVIEW: Obstetrician/Gynecologist – Brown University educated; Harvard and Tufts Faculty member; multilingual with 18 years clinical experience; seeking diversified professional practice.

PROFESSIONAL EXPERIENCE

1991 – present	Practicing with Charter Professional Services Corp as OBSTETRICIAN/GYNECOLOGIST – in a private practice serving a diverse multi-cultural population in a suburban Harvard affiliated teaching hospital: 1991 Cofounder of Salem Women's Health Associates, 400 Highland Ave., Salem, MA
1988 – 1991	OBSTETRICIAN/GYNECOLOGIST for the National Health Service Corps. Serving large Portugese and Spanish underprivileged populations through 2 neighborhood Community Health Centers (Lynn Community and North Shore Community Health Services, Lynn/Peabody, MA)

ACADEMIC APPOINTMENTS

1993 – present	CLINICAL ASSOCIATE PROFESSOR (10 years) at Harvard Medical School, Mass. General Hospital Dept. of Gynecology and Obstetrics.
1989 – present	SUPERVISING INSTRUCTOR (12 years) at Tufts Medical School in Boston, MA working with 2nd and 4th year medical school students.

HOSPITAL AFFILIATIONS

1993 – present	Massachusetts General Hospital; Boston, MA
1988 – present	Salem Hospital, Salem, MA

MEDICAL LICENSES

Massachusetts License # 59447
New Hampshire License # 10174

BOARD CERTIFICATIONS

1990	American Board of Obstetrics and Gynecology
2000	Recertified

PROFESSIONAL MEMBERSHIPS

Since 1995	Fellow of the American College of Obstetricians and Gynecologists
Since 1997	Member, Boston Obstetrical Society
Since 1997	Member, New England Obstetrical Society

OTHER PROFESSIONAL ACTIVITIES

Since 1991	Gynecologist, Part-time at Feminist Health Center; Greenland, NH
Since 1999	Speakers Bureaus for Ortho McNeil and Burlex on contraceptives.

EDUCATIONAL PREPARATION

1984-1988	Residency in Obstetrics and Gynecology Baystate Medical Center Affiliated Hospital, Tufts Medical School Springfield, MA
1980 – 1984	Doctor of Medicine Brown University Providence, RI
1983-1984	Hospital San Ignacio Bogota, Columbia Rotation in Internal Medicine and Respiratory Diseases Initiated Medical School Student Exchange Program for Brown University
1976 – 1980	Bachelor of Science (Magna cum Laude) Brown University Providence, RI

PERSONAL DATA

11689

NEW HAMPSHIRE BOARD OF MEDICINE

RECEIVED
JAN 26 1998
NH BOARD OF MEDICINE

LAWRENCE W. O'CONNELL, Ph.D.
PRESIDENT, PUBLIC MEMBER
ROBERT C. CHARMAN, M.D.
VICE PRESIDENT
MAUREEN P. KNEPP, PA-C
PARAMEDICAL PROFESSIONAL

BOARD MEMBERS
CYNTHIA S. COOPER, M.D.
PAUL F. RACICOT, M.D.
RAYMOND E. MERRILL, M.D.
WASSFY M. HANNA, M.D.

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

Name: Betsy AUGUST M.D. # 10174

Office name and address: Feminist Health Center
559 Portsmouth Ave., Greenland, NH 03840

Office telephone: 603-436-7588

Home Address:

Home telephone:

Specialty: obstetrics / gynecology Board certified: 1990, yes

Hospital affiliations: Massachusetts General, Salem Hospital

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

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-6702

NEW HAMPSHIRE BOARD OF MEDICINE

LAWRENCE W O'CONNELL, Ph D
PRESIDENT, PUBLIC MEMBER
CYNTHIA S COOPER, M.D
VICE PRESIDENT
MAUREEN P KNEPP, PA-C
VICE PRESIDENT, LEGISLATIVE AFFAIRS

BOARD MEMBERS
WASSFY M. HANNA, M.D.
BRUCE J. FRIEDMAN, M.D.
JEAN A. BARNES, PUBLIC MEMBER
DANA MERRITHEW, M.D.

December 3, 1997

BETSY S AUGUST MD

Dear Dr. August:

This is to certify that you have been granted licensure to practice medicine in the State of New Hampshire. Your license number 10174 is dated December 3, 1997.

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.

Please keep this office informed of any change in home or office address.

Sincerely,

Karen Lamoureux
Administrator

KL/db
Encl.

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-6702

10174

NEW HAMPSHIRE BOARD OF MEDICINE

LAWRENCE W. O'CONNELL, Ph. D.
PRESIDENT, PUBLIC MEMBER
CYNTHIA S. COOPER, M.D.
VICE PRESIDENT
MAUREEN P. KNEPP, PA-C
VICE PRESIDENT, LEGISLATIVE AFFAIRS

BOARD MEMBERS
PAUL F. RACICOT, M.D.
RAYMOND E. MERRILL, M.D.
WASSFY M. HANNA, M.D.
BRUCE J. FRIEDMAN, M.D.

Application No. 11089

I hereby apply for a license to practice medicine in the State of New Hampshire as a Doctor of Medicine or 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 enclosed a certified check or postal or express money order for the application fee of $250.00, check made payable to the "Treasurer, State of New Hampshire" - U.S. Funds only. Application fees are **non-refundable.**

1. PERSONAL INFORMATION:

Name: Betsy Sue AUGUST
(please print) FIRST MIDDLE LAST / MAIDEN

Home Address: _____

_____ Home Phone #: _____

Office Address: 331 Highland Ave. Salem, Ma. 01970

_____ Office Phone #: 508 - 741 - 3700

Date of Birth ___ _____ Place of Birth _____

Social Security Number ___

2. ACADEMIC EDUCATION:

Name and Location of Institutions	Dates Attended	Degree Awarded
Brown University,	9/76 — 6/80	Bachelor Science
Providence, RI.		

2 INDUSTRIAL PARK DRIVE SUITE 8 CONCORD, NH 03301-8520 TDD Access: Relay NH 1-800-735-2964 TEL. (603) 271-1203 FAX (603) 271-6702

3. **MEDICAL EDUCATION:**

Name and Location of Institutions	Dates Attended	Degree Awarded
Brown University, Medical School, Providence, R.I.	6/80 - 6/84	Doctor of Medicine

5. **FOREIGN MEDICAL GRADUATES.**

(a) Foreign graduates must submit a transcript of grades and proof of graduation from medical school. Certified copies of these documents with certified English translation is required.

(b) Foreign medical graduates must also submit original verification directly from ECFMG documenting that the applicant currently holds standard certification by ECFMG. Please indicate ECFMG #:_____

6. **POST GRADUATE EDUCATION.**

Internship and/or Residency

Program	Location	Dates
Baystate Medical Center Obstetrics and Gynecology	Springfield, Ma.	7/84 – 7/88

NH Requires at least 2 years of post graduate training in the United States or Canada. An official, original letter from the residency program verifying internship and/or residency is required.

7. **EXAMINATION.**

Name of Examination	Date of Completion	Score
National Board of Medical Examiners		

A National Board or FLEX score report form is enclosed. Please have an official transcript of your scores sent directly to the Board. If examination is by USMLE, LMCC or state examination, you must contact these organizations and have an official transcript of your scores sent directly to the Board.

8. **LICENSURE.**

Please list all states where you hold or have ever held a physician's license.

Massachusetts		

You must obtain a verification from all states where you hold, or have ever held a license. Verifications must be received directly from the licensing authority. A form is enclosed for your convenience. Please make copies as necessary.

9. Are you certified by an American Specialty Board? ✓ YES ____ NO
If yes, please provide a notarized photocopy of such certification.

	YES	NO
10. Have you ever, for any reason, lost American Specialty Board Certification?	___	✓
11. Have you been denied required recertification by any specialty boards? If yes, list each such boards and dates denied._____	___	✓
12. Has any medical malpractice claim 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?_____	✓	___
13. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name?	___	✓
14. 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?	___	✓
15. Have you ever failed any of the following examinations: the USMLE, the FLEX examination, any state board examination or have you ever failed to gain certification from the National Board of Medical Examiners?	___	✓
16. Have you ever failed a foreign licensing or certification examination?	___	✓
17. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	✓
18. 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?	___	✓
19. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	___	✓

	YES	NO
20. 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?	___	✓
21. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	___	✓
22. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, but not including traffic offenses not classified as misdemeanors?	___	✓
23. 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?	___	✓
24. Have you ever had any emotional disturbance or mental illness which has impaired or would be likely to impair your ability to practice medicine?	___	✓
25. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs?	___	✓

NOTE ON QUESTIONS 23-25: 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, please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

26. A current curriculum vitae is required.

27. An official certified copy of your birth certificate is required.

28. A total of ~~4~~ 2 reference letters are required. Letters of reference shall be provided by the following individuals:

_____ _____ _____

_____ _____

29. **AFFIDAVIT OF THE APPLICANT:**

STATE OF Massachusetts
COUNTY OF ____

I, Betsy August of ____

being duly sworn say that I am the person referred to in the above application for a license to practice medicine as a Doctor of Medicine or Doctor of Osteopathy in the State of New Hampshire; that I have studied the treatment of human ailments not less than four school years, received a degree of Doctor of Medicine or Doctor of Osteopathy; and that all the statements herein respecting age, academic and medical education, internship, state or national board examination and license, good professional standing, and all other statements made on said application are true in every respect, and that no investigation or disciplinary action is pending or has been brought against me by any state, county or local medical society, hospital or health care facility or professional medical association, except as disclosed on this application.

Betsy August, M.D., D.O.

Sworn to before me this 11th day of September, 19 97

(SEAL) Anne M Ward Notary Public

ANNE M. WARD
Notary Public
My Commission Expires Jan. 8, 1999

****

Betsy August MD
Signature of Applicant

PLEASE DO NOT WRITE BELOW THIS LINE - FOR BOARD USE ONLY:

Application received 9-16, 19 97

Fee Paid 8-11, 19 97 Check Number ____

License Number: 10174 **Date of Issue:** 12/3/97

RECEIVED
SEP 25 1997
NH BOARD OF MEDICINE

Betsy S. August, M.D., F.A.C.O.G.

Salem Women's Health Associates
331 Highland Avenue
Salem, MA 01970
508-741-3700

Education

1984-1988	Baystate Medical Center Residency in Obstetrics and Gynecology Affiliated Hospital Tufts Medical School Springfield, MA
1980-1984	Brown University Program in Medicine Doctor of Medicine Providence, Rhode Island
1976-1980	Brown University Bachelor of Science Magna Cum Laude Providence, Rhode Island
1991-present	Partner-Private Practice Salem Women's Health Associates Salem, MA

Special Education/Experience

1988-1991	National Health Service Corps Obstetrics and Gynecology practice at Lynn Community and North Shore Community Health Centers Lynn/Peabody, Massachusetts
1983	Hospital San Ignacio Rotation in Internal Medicine and Respiratory Disease Initiated medical school student exchange program for Brown University Bogaota, Columbia

Medical License	
1988-present	Massachussetts License #59447
Hospital Affiliation	
1993 - present	Massachusetts General Hospital Boston, MA
1988 - present	Salem Hospital Salem, MA
Board Certification	American Board of Obstetrics and Gynecology
1990	
Professional Membership	Fellow of the American College of Obstetrics and Gynecology
Academic Position	
1989 - present	Tufts Medical School - Clinical Instructor
1993 - present	Harvard Medical School Clinical Associate Professor Gynecology and Obstetrics

Languages

Baystate Medical Center

Springfield, Massachusetts

An Associated Hospital of Tufts University School of Medicine

hereby certifies that

Betsy S. August, M.D.

has served as

First Year Resident in Obstetrics-Gynecology, July 1, 1984 to June 30, 1985
Second Year Resident in Obstetrics-Gynecology, July 1, 1985 to June 30, 1986
Third Year Resident in Obstetrics-Gynecology, July 1, 1986 to June 30, 1987
Fourth Year Resident in Obstetrics-Gynecology, July 1, 1987 to June 30, 1988

Chairman, Department of Obstetrics-Gynecology

BAYSTATE MEDICAL CENTER, INC. INCORPORATED 1903 MASS.

Sept. 16, 1997
Anne M. Ward
ANNE M. WARD
Notary Public
My Commission Expires Jan. 8, 1999

President

Chairman, Board of Trustees

July 1, 1988

National Board of Medical Examiners

of the

United States of America

Betsy S. August, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest Clu Daeschner, Jr.
Chairman of the Board

Edithe J. Levit
President of the Board

Philadelphia Pa
July 1, 1985

Certificate No.
274987

Sept. 11, 1997
Anne M. Ward
ANNE M. WARD
Notary Public
My Commission Expires Jan. 8, 1999

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Certifies that

Betsy S. August, M.D.

having fulfilled the requirements has been elected a

Fellow

of this College

which is dedicated to the maintenance of the Highest Standards in Patient Care, Medical Education and Research in Obstetrics and Gynecology

September 30, 1991

Richard H Schwarz MD
President

Sept. 11, 1997

Anne M Ward

ANNE M. WARD
Notary Public
My Commission Expires Jan. 8, 1999

M. J. Sullivan MD
Secretary

National Board of Medical Examiners

of the

United States of America

RECEIVED
AUG 1 1 1997
NH BOARD OF MEDICINE

Betsy S. August, M.D.

having satisfied all the requirements and having successfully passed the examinations is hereby declared a

Diplomate of the National Board of Medical Examiners

Attest

C. W. Daeschner, Jr.
Chairman of the Board

Edithe J. Levin
President of the Board

Philadelphia, Pa.
July 1, 1985

Certificate No.
274987

RECEIVED

OCT 02 1997

NH Board of Registration in Medicine

THIS MUST BE SENT TO THE SCHOOL FROM WHICH YOU GRADUATED

4. **CERTIFICATE OF MEDICAL EDUCATION:**

It is hereby certified that BETSY SUE AUGUST (Your Name) matriculated in BROWN UNIVERSITY MEDICAL SCHOOL (Name of Institution) at PROVIDENCE, RI (Location of Institution) on 9/17/79 and received a diploma from this institution conferring the degree of Doctor of Medicine or Doctor of Osteopathy. on 5/28/84

Alexandra Morang
President, Secretary or Dean
Director of Medical Student Affairs

(SCHOOL SEAL)
REQUIRED

****

After completing, please return this form to the following address:

BOARD OF MEDICINE
2 INDUSTRIAL PARK DRIVE, SUITE 8
CONCORD, NEW HAMPSHIRE 03301-8520

RECEIVED
OCT 14 1997
NH Board of
Registration & Medicine

Baystate Medical Center

Springfield, Massachusetts

An Associated Hospital of Tufts University School of Medicine

hereby certifies that

Betsy S. August, M.D.

has served as

First Year Resident in Obstetrics-Gynecology, July 1, 1984 to June 30, 1985
Second Year Resident in Obstetrics-Gynecology, July 1, 1985 to June 30, 1986
Third Year Resident in Obstetrics-Gynecology, July 1, 1986 to June 30, 1987
Fourth Year Resident in Obstetrics-Gynecology, July 1, 1987 to June 30, 1988

Chairman, Department of Obstetrics-Gynecology

BAYSTATE MEDICAL CENTER, INC. INCORPORATED 1902 MASS.

President

Chairman, Board of Trustees

July 1, 1988

Baystate Medical Center

Springfield, Massachusetts

An Associated Hospital of Tufts University School of Medicine

RECEIVED
AUG 11 1997
NH BOARD OF MEDICINE

hereby certifies that

Betsy S. August, M.D.

has served as

First Year Resident in Obstetrics-Gynecology, July 1, 1984 to June 30, 1985
Second Year Resident in Obstetrics-Gynecology, July 1, 1985 to June 30, 1986
Third Year Resident in Obstetrics-Gynecology, July 1, 1986 to June 30, 1987
Fourth Year Resident in Obstetrics-Gynecology, July 1, 1987 to June 30, 1988

Chairman, Department of Obstetrics-Gynecology

BAYSTATE MEDICAL CENTER INC

President

Chairman, Board of Trustees

July 1, 1988

American Board of Obstetrics and Gynecology

COMPOSED OF MEMBERS NOMINATED BY THE
AMERICAN GYNECOLOGICAL AND OBSTETRICAL SOCIETY
AMERICAN MEDICAL ASSOCIATION
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS
ASSOCIATION OF PROFESSORS OF GYNECOLOGY-OBSTETRICS

CERTIFIES THAT

BETSY S. AUGUST, M.D.

HAVING PURSUED AN ACCEPTED COURSE OF GRADUATE STUDY AND CLINICAL WORK, HAS MET THE STANDARDS AND QUALIFICATIONS AND PASSED THE EXAMINATIONS REQUIRED BY THE AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. SHE HAS THEREBY DEMONSTRATED TO THE SATISFACTION OF THIS BOARD THAT SHE IS POSSESSED OF SPECIAL KNOWLEDGE, AND BY THE AWARD OF THIS DIPLOMA HER PROFICIENCY IN THE SPECIALTY OF OBSTETRICS AND GYNECOLOGY IS RECOGNIZED, AND SHE IS AN ACKNOWLEDGED DIPLOMATE OF THIS BOARD FROM DECEMBER 1990 THROUGH DECEMBER 2000.

DECEMBER 7, 1990

Sept. 11, 1997
ANNE M. WARD
Notary Public
My Commission Expires Jan. 8, 199

PRESIDENT

EXECUTIVE DIRECTOR

CHAIRMAN

JUN

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.)

MA

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

License #: 10174

File #: 11089

☒ Work Address:

BETSY S AUGUST MD

Womens Health Assoc
331 Highland Ave
Salem, NH 01970

☒ Home Address:

BETSY S. AUGUST, MD

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

SALEM Hospital, Salem Ma.

Massachusetts General Hospital, Boston, Ma.

Betsy August MD

(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.

Peter Augustus

Signature of Licensee (Signature Stamp Not Accepted)

5/19/98

Date

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.)

MA

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

License #: 10174 ☐

File #: 11089 ☒

BETSY S AUGUST, MD
WOMEN'S HEALTH ASSOCIATES
400 ~~331~~ HIGHLAND AVE
SALEM, ~~NH~~ 01970
Phone: MA

Phone:

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

SALEM HOSPITAL, SALEM MA MASSACHUSETTS GENERAL HOSPITAL, BOSTON

(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.

Betty Augustus
Signature of Licensee (Signature Stamp Not Accepted)

4/21/95
Date

JUN 3 0 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.)

MA

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

License #: 10174

File #: 11089

☒

Home Address

BETSY S AUGUST, MD

Phone:

☐

Work Address

WOMEN'S HEALTH ASSOCIATES
400 HIGHLAND AVE
SALEM, MA 01970

Phone: 978-741-3700

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

SALEM HOSPITAL, SALEM MA MASSACHUSETTS GENERAL HOSPITAL, BOSTON

(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.

Betsy Augustus
Signature of Licensee (Signature Stamp Not Accepted)

5/9/00
Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

#894

RENEWAL APPLICATION

For expiration on: (date) 6/30/2002

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.)

MA

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

License #: 10174

File #: 11089

☐

Home Address

BETSY S AUGUST, MD

Phone:

☐

Work Address

WOMEN'S HEALTH ASSOCIATES
400 HIGHLAND AVE
SALEM, MA 01970
Phone: 978*741-3700

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

SALEM HOSPITAL- SALEM, MA
MASS GENERAL HOSPITAL- BOSTON, MA

(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.

Betty Augustus

Signature of Licensee (Signature Stamp Not Accepted)

6/30/01

Date

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-693 MAR 2 4 2005

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

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.)
MA

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

License #: 10174

☐ Home Address

BETSY S AUGUST, MD
[redacted]
[redacted]
Phone: [redacted]

File #: 11089

☑ Work Address

FEMINIST HLTH CTR PORTSMOU
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

Phone: 603*436-7588
Business Fax Number: N/A
Business Email Address: N/A

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
SALEM HOSPITAL	SALEM	MA		☑	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA		☑	☑	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(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.

Betty August MD — 3/20/05

Signature of Licensee (Signature Stamp Not Accepted) — Date

APR 2 0 2007

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RECEIVED
APR 1 9 2007
NH BOARD

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.) MA

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

License #: 10174

File #: 11089

☑ Work Address

BETSY S AUGUST, MD
FEMINIST HLTH CTR PORTSMO
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

Phone: 603*436-7588
Business Fax Number: NONE
Business Email Address: NONE

☐ Home Address

[redacted]

[redacted]

Phone: [redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
SALEM HOSPITAL	SALEM	MA		☑	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA		☐	☑	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(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.

Peter Augustine — Signature of Licensee (Signature Stamp Not Accepted)

3/25/07 — Date

APR 14 2009

STATE OF NEW HAMPSHIRE

RECEIVED

APR 10 2009

NH BOARD

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

Telephone #: 603-271-6934

RENEWAL APPLICATION

For expiration on: 06/30/2011

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

Currently Board Certified? (Y/N) Y OBG

Please list ABMS Board Specialty: _____

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

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 #: 10174

File #: 11089

☒ Work Address

BETSY S AUGUST, MD
FEMINIST HLTH CTR PORTSMO
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

Phone: 603*436-7588
Business Fax Number: NONE
Business Email Address: NONE

☐ Home Address

[redacted]

Phone: [redacted]

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

Hospital			Privilege Full	Courtesy	Consult
SALEM HOSPITAL	SALEM	MA	☑	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA	☐	☑	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(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.

Betty Anne Stuart

Signature of Licensee (Signature Stamp Not Accepted)

4/6/09

Date

APR 11 2011 RECEIVED

STATE OF NEW HAMPSHIRE APR 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: 4-6-11 Check #

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.) MA

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 #: 10174

File #: 11089

☐ Work Address

BETSY S AUGUST, MD
FEMINIST HLTH CTR PORTSMOU
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

Phone: 603*436-7588
Business Fax Number: NONE
Business Email Address: NONE

☐ Home Address

[redacted]

Phone: [redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
SALEM HOSPITAL	SALEM	MA		☑	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA		☐	☑	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(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.**

Betsy Augustus — 4/3/11

Signature of Licensee (Signature Stamp Not Accepted) — Date

MAY 0 1 2013

STATE OF NEW HAMPSHIRE

RECEIVED
APR 2 9 2013
NH BOARD

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

RECEIVED
APR 15 2013
NH BOARD

Telephone #: 603-271-6934

RENEWAL APPLICATION

For expiration on: 06/30/2013

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 4/15/13 Check # 385

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.

RECEIVED
APR 29 2013
NH BOARD

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.) MA NH

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 #: 10174 File #: 11089

☐ Work Address

BETSY S AUGUST, MD
FEMINIST HLTH CTR PORTSMOU
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*436-7588
Business Fax Number: [redacted]
Business Email Address: [redacted]

Phone: [redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
SALEM HOSPITAL	SALEM	MA		☑	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA		☐	☑	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(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:** _

**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?		X
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?		X
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		X
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		X
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		X
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?		X
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		X
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.		X
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?		X
10. Have any medical malpractice claims been made against you? See attached reporting form.	X	

****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.**

Betty AUGUSTINO
Signature of Licensee (Signature Stamp Not Accepted)

4/12/13
Date

Kenneth L. Noller, M.D.
Director of Evaluation
American Board of Obstetrics and Gynecology
2915 Vine Street
Dallas, TX 75204
Phone: (214) 871-1619
Fax: (214) 871-1943

April 27, 2013

Betsy Sue August, M.D.
Betsy August M.D. LLC

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2012 Maintenance of Certification Part II assignments. You have earned 35 AMA Category 1 CME credits. These will be awarded by the American College of Obstetricians and Gynecologists (ACOG).

Documentation of completion of the MOC process will be furnished to the engraving company.

Your certification status in Obstetrics and Gynecology on April 27, 2013 is "active" through 12/31/2013. The MOC process requires a new application and participation each year.

Please use this letter to provide documentation of your status for your hospitals. Please remember that you must re-apply for MOC each year. The application for the 2013 MOC process will be available through your ABOG Member Login page beginning in November, 2012 .

Sincerely yours,

Kenneth Noller, M.D.
Director of Evaluation

KLN

ABOG ID: 884108

A439520

MAY 0 7 2015

RECEIVED
MAY 04 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: 5/4/15 Check # 4016

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.) MA

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 #: 10174

File #: 11089

☑ Work Address
BETSY S AUGUST, MD
FEMINIST HLTH CTR PORTSMOU
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

☐ Home Address
[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*436-7588
Business Fax Number: [redacted]
Business Email 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 Privileges			Full	Courtesy	Consult	Other
SALEM HOSPITAL	SALEM	MA	☑	☐	☐	☐
MASS GENERAL HOSPIT	BOSTON	MA	☐	☑	☐	☐
Beverly Hospital			☑	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

(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)?	yes	
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.**

Patricia Augustine — 4/8/15

Signature of Licensee (Signature Stamp Not Accepted) — Date

MAY 18 2017

RECEIVED
MAY 18 2017
BOARD OF MEDICINE

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: 06/30/19

Renewal Fee: $350.00

For Office Use Only: Date Pd: 5/18/17 Check # 1338

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.) MA

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 #: 10174

File #: 11089

☐ Home Address

BETSY S AUGUST, MD

[redacted]

☐ Work Address

FEMINIST HLTH CTR PORTSMOU
559 PORTSMOUTH AVE PO BOX 4
GREENLAND, NH 03840

Please provide current Email, Fax and Phone Numbers below:

Phone: [redacted]

Phone: 603*436-7588
Business Fax Number:
Business Email Address: [redacted]

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

Hospital Privileges

SALEM HOSPITAL	SALEM	MA
MASS GENERAL HOSPITAL	BOSTON	MA
BEVERLY HOSPITAL	BEVERLY	MA

(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: MA Expiration Date: 6/30/18	✓	

****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.**

Betsy Augustus
Signature of Licensee (Signature Stamp Not Accepted)

4/18/17
Date

Renewal Template

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

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 04/08/2019

MEDP REN Malpractice

MEDP Have any medical malpractice claims been made against you? N 04/08/2019

MEDP REN Other location

MEDP Are you practicing in any other location other than the principal business address listed on this renewal? If so, please attach a list with all additional business address(es) and business phone number(s). Y 04/08/2019

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 04/08/2019

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]04/08/2019

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 04/08/2019

MEDP REN Actively Practicing

MEDP Are you actively practicing medicine in NH? Y 04/08/2019