Renee M. Johannensen, MD
[redacted]

February 13, 2018

Office of Professional Licensure and Certification
Of New Hampshire
1121 South Fruit Street
Concord, NH. 00301

To Whom It May Concern,

I have had my name legally changed and would like my New York medical license to reflect this name change.

My New Hampshire Medical License number is: 13120

The license was formally under the name of Renee Novello

Attached please find a copy my court ordered name change.

If you have any questions, please feel free to call me on my cell phone at [redacted]

Thank you very much.

Sincerely,

Renee M. Johannensen, MD

2/26/18

contact [redacted]

VERMONT SUPERIOR COURT
WINDSOR UNIT

PROBATE DIVISION
DOCKET NO. 45-2-18 Wrpr

RECEIVED
FEB 20 2018

ORDER CHANGING NAME

THE HONORABLE PROBATE COURT FOR THE DISTRICT OF WINDSOR, SS.

Whereas, Renee Johannensen Novello of West Windsor, Vermont has appeared before this court and requests that their name be changed from: Renee Johannensen Novello to Renee Marie Johannensen.

Name shown on Birth Certificate: Renee Maria Johannensen

Name to be shown on Birth Certificate: Renee Marie Johannensen

Date of Birth: [redacted]

Place of Birth: [redacted]

WHEREAS, the petitioner has complied with the requirements of Title 15, V.S.A. §811 and V.R.P.P. 80.6. It is ADJUDGED and DECREED that the petitioner is hereafter to be known and called Renee Marie Johannensen.

Dated at Woodstock, Vermont in said District this 12th day of February, 2018.

Probate Judge

Date 2-12-18
Certified to be a true copy of the original as appears on file in this office.
Margaret Lamos
Vermont Superior Court
Windsor Unit

FILED
FEB 12 2018
VERMONT SUPERIOR COURT
WINDSOR UNIT

To: New Hampshire State Board of Medicine
From: Renee Novello, MD License #: 13120
Date: 1/29/08

Re: Incorrect address on Website

Attn: Nichole

As per our brief telephone conversation this morning, I am alerting you that my address is listed incorrectly on the NHBM Website. It lists my address as [redacted] and my phone number at [redacted] My address should be Mt. Ascuntey Hospital, 289 County Road, Windsor, VT 05089 and the telephone number there is 802-674-7300. Does it matter that I work at more than one hospital? If so, please call me at [redacted] so that I can up date that information also.

Many thanks!

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

June 7, 2006

RENEE NOVELLO MD
[redacted]

Dear Dr. Novello:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 13120, is dated June 7, 2006, and is enclosed with this letter.

Please make note of the expiration date. 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.

Application for Physician Licensure

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: Novello
First Name: Renee
Middle Name:
Suffix:
Maiden Name: Johannensen
M.D. ☒ D.O. ☐

Renee Johannensen- Novello
All other names used

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.

Practice Address
☒ Public Access
☐ Mailing

Street: 300 2nd Avenue
City: Long Branch State: NJ ZIP Code: 07740

Telephone: 732-923-6795
Fax: [redacted]
E-mail address: [redacted]
Alternate Phone:

Home Address
☒ Public Access
☐ Mailing

Street: [redacted]
City: [redacted] State: [redacted] ZIP Code: [redacted]

Telephone: [redacted]
Fax:
E-mail address: [redacted]
Alternate Phone:

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]

Date of Birth (mm/dd/yyyy) | Birth City | Birth State | Birth Country

F
Gender

[redacted]
Social Security Number

Are you a U.S. Citizen? [redacted]

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.

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 (attach additional pages if necessary)

1. School Name UMDNJ - New Jersey Medical School
Address 185 S. Orange Avenue
City Newark
State NJ
ZIP Code 07103-2757
Country U.S.A.
Attendance Dates (From – To)
Graduation Date 5/1998
Degree MD

2. School Name
Address
City
State
ZIP Code
Country
Attendance Dates (From – To)
Graduation Date
Degree

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 _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Completion Date _____

Degree (Fifth Pathway Certificate) _____

Institution name where rotations performed _____

Address _____

City _____

State _____

ZIP Code _____

Country _____

Attendance Dates (From - To) _____

Certification Date _____

Applicant Name: Renee Novello, MD Date: 2/12/06

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. Additionally, the postgraduate program must provide this Board with the Program Director's recommendation letter. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training (copy and attach additional pages if necessary)

Complete name and address of hospital where training was conducted (Do Not Abbreviate)

1.Hospital Name: Monmouth Medical Center
Hospital Address: 300 2nd Avenue
City: Long Branch
State: NJ
ZIP Code: 07740
Country: U.S.A.

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

Department/Specialty: obstetrics & gynecology

From: 7 / 1999 To: 6 / 2003 Successfully Completed? Yes ☒ No ☐ In Progress ☐
Month Year Month Year

2.Hospital Name:
Hospital Address:
City:
State:
ZIP Code:
Country:

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

Department/Specialty:

From: / To: / Successfully Completed? Yes ☐ No ☐ In Progress ☐
Month Year Month Year

Applicant Name: Renee Navello, MD Date: 2/12/06

6. Postgraduate Training (continued)

3.Hospital Name_____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

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

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

4.Hospital Name_____

Hospital Address _____

City _____

State _____

ZIP Code _____

Country _____

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

Department/Specialty: _____

From: ____ / ____ To: ____ / ____ Successfully Completed? Yes ☐ No ☐ In Progress ☐

Month Year Month Year

Applicant Name: Renee Novello, MD Date: 2/12/06

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	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)	Number of attempts
State Board Exam NJ (State)	N/A	☐ P ☐ F	N/A
FLEX Pre-1985		☐ P ☐ F	
FLEX Component 1		☐ P ☐ F	
FLEX Component 2		☐ P ☐ F	
LMCC – Single		☐ P ☐ F	
LMCC – Part I		☐ P ☐ F	
LMCC – Part II		☐ P ☐ F	
NBME Part I		☐ P ☐ F	
NBME Part II		☐ P ☐ F	
NBME Part III		☐ P ☐ F	
NBOME Part I		☐ P ☐ F	
NBOME Part II		☐ P ☐ F	
NBOME Part III		☐ P ☐ F	
SPEX		☐ P ☐ F	
COMVEX		☐ P ☐ F	
COMLEX		☐ P ☐ F	
USMLE Step I		☒ P ☐ F	1
USMLE Step II		☒ P ☐ F	1
USMLE Step III		☒ P ☐ F	1

Applicant Name: Renee Novello, MD Date: 2/12/06

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 healthcare 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 – MD or DO only – attach additional pages if necessary

1. State/Province NJ Type MD (MD, DO, etc) License Number 25MA072624 00 Status ACTIVE Issue Date 6/26/2001
2. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
3. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
4. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
5. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
6. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
7. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
8. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
9. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____
10. State/Province ____ Type ____ (MD, DO, etc) License Number ____ Status ____ Issue Date ____

Applicant Name: RENEE Navello, MD Date: 2/12/06

All Other Healthcare Licensure/Certification (e.g., RN, PA, etc.) - attach additional pages if necessary.

1. State _____ Type _____ License Number _____ Status _____ Issue Date _____
2. State _____ Type _____ License Number _____ Status _____ Issue Date _____
3. State _____ Type _____ License Number _____ Status _____ Issue Date _____
4. State _____ Type _____ License Number _____ Status _____ Issue Date _____
5. State _____ Type _____ License Number _____ Status _____ Issue Date _____

10. Chronology of Activities: Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date, leaving no time period unaccounted for in your resume. Use an additional page to account for non-professional activities and any other gaps in time between professional experiences, including military duty.

10. Chronology of Activities (copy and attach additional pages if necessary)

Dates: From/To	Practice/Employment
1. From: Month: 7/1999 Year: ~~7/2000~~ To: Month: July Year: 2003	Practice/Employment Name: Monmouth Medical Center Practice/Employment Address: 300 2nd Avenue City: Long Branch State: New Jersey ZIP Code: 07740 Country: Monmouth Position and Department: Resident/ Oblgyn % Clinical: _____ % Administrative: _____ Employment ☒ Staff Privileges ☐ Affiliation ☐ Other: _____
2. From: Month: October Year: 2003 To: Month: Present Year: _____	Practice/Employment Name: Monmouth Medical Center Practice/Employment Address: 300 2nd Avenue City: Long Branch State: New Jersey ZIP Code: 07740 Country: Monmouth Position and Department: Director of Clinic Services % Clinical: 85 % Administrative: 15 Employment ☒ Staff Privileges ☒ Affiliation ☐ Other: _____

Applicant Name: Renee Novello, MD Date: 2/12/06

Renee Johannensen Novello
Additional Page

5/98-7/99 - Time between medical school and residency. Time devoted to family. Volunteered at Planned Parenthood, continued to do research in Reproductive Endocrinology laboratory at UMDNJ, volunteer work for Monmouth Historical Society, children's schools and sports programs.

7/03-10/03 – Time off between residency and current position.

3. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
4. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
5. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____
6. From: Month: _____ Year: _____ To: Month: _____ Year: _____	Practice/Employment Name _____ Practice/Employment Address _____ City _____ State _____ ZIP Code _____ Country _____ Position and Department _____ % Clinical _____ % Administrative _____ Employment ☐ Staff Privileges ☐ Affiliation ☐ Other _____

Applicant Name: _____ Date: _____

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.

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 or shall make with respect thereto are true, that I am the original and lawful possessor 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 licensure or permit to practice medicine.

R Novello

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

Renee Novello, MD

Applicant's Printed Last Name

Renee J.

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

4/12/06

Date of Signature

NOTARY

Dated 4/12/06 Signed Carol S Geiss

State of New Jersey County of Monmouth

SUBSCRIBED AND SWORN TO before me this 12 day of April 2006

My commission expires CAROL S. GEISS NOTARY PUBLIC OF NEW JERSEY My Commission Expires Jan 17, 2007 (NOTARY PUBLIC SIGNATURE & SEAL) Carol S Geiss

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Applicant Name Renee J. Novello, MD Date 4/12/06

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

	YES	NO
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?		X
13. 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?		X
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?		X
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?		X
16. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs or undergone treatment for such?		X

Anticipated Practice Location(s) (if known):

R Novello
Applicant's Signature

Novello
Applicant's Printed Last Name

4/11/06
Date of Signature

For Board Use Only:

Application Received: 4/19, 2006 Fee Paid: $250 Check#: 4884

License Number: _____ Date of Issue: _____

Renee J. Novello, MD (nee Johannensen)

[redacted]

Curriculum Vitae

Medical Education:
8/92-5/98 University of Medicine & Dentistry of New Jersey – New Jersey Medical School, Newark, NJ Degree: MD 5/1998
Elected Alpha Omega Alpha Honor Medical Society (inducted as a third year medical student)
American Medical Women's Association – Janet M. Glasglow Memorial Achievement Citation
Merck Manual Award for Academic Excellence
Elected to Sigma Xi Scientific Research Honor Society
Commendation Letter- Department of Pathology
Student Course Representative – Cell & Tissue Biology & Genetics
Admissions Liaison

Undergraduate Education:
1/86-5/90 Rutgers University – Newark
BA, Biology
Elected Phi Beta Kappa
High Honors
College Honor Program
Elected Beta Beta Beta - Biological Honor Society
Dean's List – All four years

Residency:
07/99-6/03 Monmouth Medical Center
300 2nd Avenue, Long Branch, NJ 07740
Resident: Obstetrics and Gynecology
Chief Resident: 7/02-6/03
Awards: Dr. Robert M. Mackensie Award (to Resident who contributed most to overall teaching program and patient care in field of OB/GYN) 2001, 2003
Highest In-service score – all four years
Highest in-service score for Level – all four years
OB/GYN Resident Physician Research Award – 2000, 2001, 2002

Licensure:
State of New Jersey - 2001unrestricted since issued

Board Certification:
Board Certified American College of Obstetrics and Gyncology 1/2006 expires 12/31/2011

Medical Employment:
9/03 – Present

Monmouth Medical Center
300 2nd Avenue, Long Branch, NJ 07740
Department of Obstetrics and Gynecology
Director of Clinic Services

Director of general obstetrics, gynecology and colposcopic hospital based clinics, general hospital clinic service in patient obstetrical, gynecologic and antenatal in-patient services, and general clinic service obstetrical and gynecologic surgery.

Teaching and Research:
Coordinator of resident research efforts. 2005 submitted 5 projects, 1 awaiting publication in national journal

Lecture series, presentations and extensive clinical training of OB\Gyn residents

Lecture series and clinical training for medical students from Drexel University College of Medicine and St. George University School of Medicine. Application pending for assistant professor.

Research
6/98-6/99

UMDNJ & Albert Einstein College of Medicine, Bronx, NJ
Reproductive Endocrinology
Role of progesterone on regulation of LH secretion and the regulation of the menstrual cycle. This research came out of the work I did earlier with HMG-CoA reductase inhibitors & studying pooled progesterone measurements.

2/95-6/96

UMDNJ-New Jersey Medical School
Research Assistant
Worked in a reproductive endocrinology lab initially performing assays and later helping to refine assays. Research dealt with the effects of HMG-CoA reductase inhibitors on the menstrual cycle. Sponsored by Merck

9/88-5/90 – Rutgers University – Newark
Research Assistant – Student
Senior Thesis was derived from work performed in the Physical Biochemistry Laboratory. We isolated and studied the physical and biochemical properties of Rhodopsin and other membrane proteins.

Residency Research Topics: Case Report on Fetal Triploidy and Acute Fatty Liver of Pregnancy, Case Report Disseminated Gonococcal disease in Pregnancy, Investigation of cost effectiveness of Bacterial Vaginosis with Gram stain versus Femcard (Research award given), and the investigation to determine if pregnancy women over utilization medical services to determine the gender of their fetus (Research award given).

Publications:
6/98
Excellent Correlation of a Single Measurement of Pregnanediol Glucuronide (PDG) from Whole Cycle Pooled Urine with Mean Daily PDG. Renee Johannensen Novello, Yesim Endaz, Tovaghgol Adel, Frank Curvin, Nanette Santoro, MD
10th International Society of Endocrinology

Spanish Lessons for Residents Increase Patient Satisfaction in a Predominately Spanish Population Clinic. L. Silva, K. Rao, R. Novello
Presented at 2006 APGO Conference in Orlando Florida

Professional Organizations:
AMA – American Medical Association
ACO&G – American College of Obstetrics and Gynecology
APGO – Association of Professors of Gynecology and Obstetrics

Medical Committees:
Monmouth Medical Center – Performance Improvement Committee
Monmouth Medical Center – General Medical Education Committee
Monmouth Medical Center – OB/GYN Education Committee

Volunteer Experience & Community Service
Current: Monmouth Healthcare Foundation*
Monmouth Medical Center*
Foodbank of Monmouth County*
Rumson Country Day School*
Monmouth University*
Monmouth Historical Society
Monmouth Conservation
Prevention First (Drug Education for Children)

*Spouse is member of Board of Trustees of these organizations

9/98-6/99
& Current Planned Parenthood of Central New Jersey
Initially as a general volunteer
Currently as a Clinical volunteer

8/90-12/93 Mountainside Hospital
Volunteer in Departments of Surgery and Obstetrics

9/86-12/86 YMCA – Developed and ran Free Gymnastics Program

Other Employment:

6/84-12/89
Arnhold and S. Bleichroeder, Inc.
Syndicate Associate – Syndication Department
Registered Representative Series 7 & 63
Distribution of initial public offerings and other new public security issues.
(Held this job full time through out college)
New York, NY

8/82-5/84
Federal Reserve Bank of New York
Economic Research Department – Administrative Assistant
New York, NY

Gaps in CV:

5/90-8/92 Time dedicated to care of first two children born [redacted] This was time interval between college and medical school. This period of time also included the development of Far Hills Securities, a successful international investment banking firm founded with spouse of which I still maintain an ownership interest.

6/93-8/94- Approved leave of absence from medical school for birth of 3rd child. This was after 1 completed year of medical school

5/95-11/95 – Approved leave of absence from medical school due to 3 very young children at home. Continued to do research as a Research Assistant at UMDNJ – New Jersey medical school, Reproductive Endocrinology Department.

5/98-7/99 - Time between medical school and residency. Time devoted to family. Volunteered at Planned Parenthood, continued to do research in Reproductive Endocrinology laboratory at UMDNJ, volunteer work for Monmouth Historical Society, children's schools and sports programs.

Personal: [redacted]

DIPLOMATE

Sandra Lynn Esposito
Notary Public State of New Jersey
My Commission Expires 08/16/2009

RECEIVED BY PHYSICIAN

RECEIVED
APR 19 2006
NH BOARD

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
ASSOCIATION OF PROFESSORS OF GYNECOLOGY AND OBSTETRICS

Obstetrics and Gynecology

Renee Johannensen Novello, 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 JANUARY, 2006 THROUGH DECEMBER 31, 2011
JANUARY 13, 2006

President _____ Executive Director _____

ABO+G
First in Women's Health

DIPLOMATE NO. 9007823

NOVELLO, RENEE MD
MONMOUTH MEDICAL CENTER
300 WND AVENUE

LONG BRANCH NJ 07740-0000

Sandra Lynn Esposito
Notary Public State of New Jersey
My Commission Expires 08/16/2009

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	10-31-2007	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
[redacted]	PRACTITIONER	11-02-2004

NOVELLO, RENEE MD
MONMOUTH MEDICAL CENTER
300 WND AVENUE

LONG BRANCH NJ 07740-0000

ADDRESS CHANGE REQUEST [redacted]

NOVELLO, RENEE MD

New Address

City State Zip Code

Signature See back for additional information. Date

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

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	10-31-2007	FEE PAID

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
[redacted]	PRACTITIONER	11-02-2004

NOVELLO, RENEE MD
MONMOUTH MEDICAL CENTER
300 WND AVENUE

LONG BRANCH NJ 07740-0000

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

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

Form DEA-223 (11/03)

RECEIVED
MAY 01 2008
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

435

RENEWAL APPLICATION

For expiration on: 06/30/2010

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
Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NJ VT *NEW

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

License #: 13120

File #: 14281

☐ Work Address

RENEE NOVELLO, MD
MT ASCUNTEY HOSP
289 COUNTY RD
WINDSOR, VT 05089

Phone: 802-674-7300
Business Fax Number: [redacted]
Business Email Address:

☐ Home Address

[redacted]

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

Hospital	Privilege	Full	Courtesy	Consult
NONE		☑	☐	☐
Mt. Ascutney Hospital - Windsor, VT		☑	☐	☐
Dartmouth Hitchcock Medical Ctr. Lebanon, NH		☑	☒	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐
		☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		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.

R Overlund

Signature of Licensee (Signature Stamp Not Accepted)

4/28/08

Date

MAY 07 2010

RECEIVED
MAY 06 2010
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 06/30/2012

Renewal Fee: $300.00

For Office Use Only:
Date Pd: 5-6-10 Check # 980

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.) NJ VT

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 #: 13120 File #: 14281

☐ Work Address

RENEE NOVELLO, MD
~~MT ASCUNTEY HOSP~~
~~289 COUNTY RD~~
~~WINDSOR, VT 05089~~

1. Planned Parenthood
West Lebanon Health Ctr.
89 South Main Street
West Lebanon, NH 03784

~~802~~
Phone: ~~802-674-7300~~
Business Fax Number: [redacted]
Business Email Address: [redacted]

2. Dartmouth Hitchcock Medical Ctr.
~~Department of~~
OB/Gyn
1 medical Center Dr., Lebanon, NH 03756

☒ 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
MT ASCUTNEY HOSPITA	WINDSOR	VT		Error ☑	☒	☐
DARTMOUTH HITCHCOC	LEBANON	NH		☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	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.**

R Mowellend
Signature of Licensee (Signature Stamp Not Accepted)

5/3/2010
Date

Renee J. Novello, MD
[redacted]

May 3, 2010

State of New Hampshire
Board of Medicine
2 Industrial Park Drive
Suite 8
Concord, NH 03301

Dear Sirs;

I wanted to clarify the changes to my renewal application.

Work address:

No long is Mt. Ascutney Hospital

New work addresses are:

(Primary place of employment)
Planned Parenthood of Northern New England
West Lebanon Health Center
89 South Main Street
West Lebanon, NH 03784

Dartmouth Hitchcock Medical Center
Department of OB/GYN
1 Medical Center Drive
Lebanon, NH 03756

Work numbers: Planned Parenthood: 603-298-7766
Dartmouth Hitchcock Medical Center: 603-653-9289

If you have any questions at all, please feel free to contact me at the above telephone numbers or at my home [redacted] or cell phone [redacted].

Sincerely,

Renee Novello, MD

JUN 04 2012

RECEIVED
MAY 29 2012
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 06/30/2014

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 5/29/12 Check # 618048

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.) NJ VT NY

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 #: 13120

File #: 14281

☐ Home Address

RENEE NOVELLO, MD
[redacted]

☐ Work Address

DHMC/OB/GYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

Phone: 603-653-9289
Business Fax Number:
Business Email Address: [redacted]

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

Hospital			Privilege	Full	Courtesy	Consult
~~MT ASCUTNEY HOSPITA~~	~~WINDSOR~~	~~VT~~		☐	☑	☐
DARTMOUTH HITCHCOC	LEBANON	NH		☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐
				☑	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

Social Security Number [redacted]

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

In the past 24 months:	**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.**

Signature of Licensee (Signature Stamp Not Accepted)

3/31/2012
Date

APR 09 2014

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

RECEIVED
APR 04 2014
NH BOARD

BOARD OF MEDICINE
121 South Fruit Street, Suite 300
Concord, NH 03301-2412

RENEWAL APPLICATION

Renewal Fee: $350.00

For expiration on: 6/30/2016

For Office Use Only:
Date Pd: 4/4/14 Check # 552

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

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

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

Specialty: OBG

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

Currently licensed in the states of: (2 letter state abbrev.) NJ VT NY

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 #: 13120

File #: 14281

☑ Home Address

RENEE NOVELLO, MD
[redacted]

Phone: [redacted]

☑ Work Address

DHMC/OB/GYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

Please provide current Email, Fax and Phone Numbers below:

Phone: 603-653-9289
Business Fax Number: [redacted]
Business Email Address: [redacted]

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

Hospital Privileges			Full	Courtesy	Consult	Other
DHMC	LEBANON	NH	☑	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		✓
4. Have you been treated, other than through the 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.		✓
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 the secondary business address(es) and business phone number(s).	✓	

****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] 3/29/14

Signature of Licensee (Signature Stamp Not Accepted) Date

Renee Novello

Other practice locations:

1. Planned Parenthood of Northern New England

    a. West Lebanon New Hampshire location:
    89 Main Street
    West Lebanon, NH 03784
    603-298-7766

    b. Burlington Vermont location:
    183 St. Paul Street
    Burlington, VT 05401
    802-863-6326

2. Planned Parenthood of New York City

    Margaret Sander Center location
    26 Bleeker Street
    New York, NY 10012
    212-965-7000

Home
Public Resources
Examinations
Fees and Deadlines
Downloads
Important Dates
FAQ
Diplomate Verification
Physician Support
About Us
News
Policies
Value of MOC

SEARCH

Diplomate Verification Search

LOGIN

Renee Johannensen Novello, M.D.

Status as of 4/8/2014

Below are all certifications held by this physician with ABOG.

ABOG ID: 9007823 [redacted]

Obstetrics and Gynecology Certification		
Original Certification Date	Certification Status	Meeting Requirements of Maintenance of Certification
1/13/2006	Valid through: 12/31/2014	YES

Search Again

To purchase a copy of this status information sent from ABOG
Purchase Status Letter
The letter will contain the information above and be sent directly to an address of your choosing

MAY 11 2016

RECEIVED
MAY 03 2016
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

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

RENEWAL APPLICATION

Renewal Fee: $350.00 ✓

For expiration on: 06/30/2018

For Office Use Only: Date Pd: 5/3/16 Check # 824

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.) NJ VT NY

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 #: 13120

File #: 14281

☐ Home Address

RENEE NOVELLO, MD
[redacted]

☐ Work Address

DHMC/OB/GYN
ONE MEDICAL CENTER DR
LEBANON, NH 03756

Please provide current Email, Fax and Phone Numbers below:

Phone: 802*436-2910

Phone: 603-653-9289
Business Fax Number: [redacted]
Business Email Address:

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

Hospital Privileges

DHMC LEBANON NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

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

****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 of Licensee (Signature Stamp Not Accepted)

4/3/16
Date

Renee Johannensen Novello, MD
[redacted]

Other business addresses:

Planned Parenthood of Northern New England:

1. 183 St. Paul Street, Burlington, VT 05401
2. 79 S Main St, White River Junction, VT 05001
3. 24 Pennacook St, Manchester, NH 03104

Planned Parenthood of New York City

1. 26 Bleecker St, New York, NY 10012

MAY 02 2018

RECEIVED
APR 12 2018

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

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

RENEWAL APPLICATION

For Office Use Only: Date Pd: 4/12/18 Check # 963
$350

For expiration on: 06/30/2020 Renewal Fee: $350.00
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 business or home address within 30 days of the change.**

Specialty: Obstetrics & Gynecology
Currently Board Certified? (Y/N) Yes **(If yes, provide proof of board certification.)**
Please list ABMS Board Specialty:
Currently licensed in the states of: (2 letter state abbrev.)

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 #: 13120

☐ Home Address

RENEE M JOHANNENSEN, MD
[redacted]

☐ Work Address

RENEE M JOHANNENSEN, MD
DHMC/OB/GYN
ONE MEDICAL CENTER DR
LEBANON NH 03756

Please provide current Email, Fax and Phone Numbers below:

PHONE: [redacted]
FAX:
EMAIL:

PHONE: 6036539289
FAX: [redacted]
EMAIL: [redacted]

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

DHMC LEBANON NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		X
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?		X
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?		X
4. Have you been treated, other than through the N.H. Professionals 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
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).	X	
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	X	
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: ~~NH~~ VT Expiration Date: 10/31/2019 10/04/2020	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 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] 3/10/18

Signature of Licensee (Signature Stamp Not Accepted) Date

Renee M. Johannensen, MD
[redacted]

March 10, 2018

Board of Medicine
NH Office of Professional Licensure and
Certification
121 South Fruit Street
Suite 301
Concord, NH. 03301

To Whom It May Concern,

Question number 9 on the Board of Medicine Renewal application requests the name and address of additional business addresses phone numbers that I practice at besides the one listed on the front of the form.

These are the other locations that I practice:

Planned Parenthood of Northern New England
78 Hercules Drive, Suite 110
Colchester, VT. 05446
802-448-9778

Sites include: Manchester, NH
White River Junction, VT
Burlington, VT
Rutland, VT

Planned Parenthood of New York City
26 Bleecker Street
New York, NY. 10012
212-274-7235

Sincerely,

Renee M. Johannensen, MD

contact [redacted]