NEW HAMPSHIRE BOARD OF MEDICINE

February 7, 2001

HEIDI L MEINZ MD
[redacted]

Dear Dr. Meinz:

Congratulations, your application for licensure has been granted by the New Hampshire Board of Medicine. Your license, numbered 11180, is dated February 7, 2001, and is enclosed with this letter.

Please make note of the expiration date. You are required to renew your license annually and forms for that purpose will be forwarded to you at the address on file with the Board in April of each renewal year. 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,

Suzanne Amidon, J. D.
Administrator

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

RECEIVED

JAN 19 2001

NH BOARD OF MEDICINE

RECEIVED BY PHYSICIAN

New Hampshire Board of Medicine

Application for Licensure by Endorsement

Staple your application fee to the upper left-hand corner of this page.

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

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

Heidi Lee
First Name Middle Name

Office Address

150 Tarrytown Road
Number and Street Apartment Number

Manchester NH 03103-2767
City State Zip (or postal) Code

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

[redacted]
City State Zip (or postal) Code

Telephone Numbers

Business: (603) 622-3162 Home: [redacted]

Other: (___)_____ Fax: [redacted]

Identifying Information

Date of Birth: [redacted] Place of Birth [redacted]
Month Day Year City State

Social Security Number: [redacted]

For Board Use Only:

Application Received: 1-19, 2001 Fee Paid: 250.00 Check#: 15924

License Number: 11150 Date of Issue: 2-7-01

1/19/00

Application for Licensure by Endorsement (continued)

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.**

RI _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

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 claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (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, state board examination or failed to gain certification from the National Board of Medical Examiners?		✓
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)?		✓

1/19/00

RECEIVED BY PHYSICIAN

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?	____	✓
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 emotional disturbance 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?	____	✓

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

Anticipated Practice Location(s) (if known):

Manchester Obstetrical Associates, PA
150 Tarrytown Road
Manchester NH 03103-2767

I, Heidi L. Meinz, MD
(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 $250.00, 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.

Heidi L. Meinz, MD	Lee
Typed/Printed Last Name — First Name	Middle Name
Heidi L. Meinz MD	01-16-01
Applicant's Signature	Date of Signature

1/19/00

RECEIVED BY PHYSICIAN

AFFIDAVIT OF THE APPLICANT

STATE OF Rhode Island
(where applicant resides)

COUNTY OF [redacted]
(where applicant resides)

I, Heidi Lee Meinz MD of [redacted]
(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, 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.

Heidi L Meinz MD
Applicant's Signature

MEINZ	Heidi	Lee
Last Name	First Name	Middle Name

01/04/01
Date of Signature

Sworn to before me this 4th day of January, 2001

Eleanor V. Merchant
Notary Public signature

04/23/2002
Date Commission Expires:

Eleanor V. Merchant, Notary Public
My Commission Expires: 4/23/02

[Affix Seal Here]

1/19/00

Heidi L. Meinz, M.D.

[redacted]

EDUCATION AND TRAINING

Brown University, Women and Infants' Hospital
Providence, Rhode Island
1997-Present, Obstetrics and Gynecology Residency

Allen Berry Health Center
Providence, Rhode Island
1999-Present, Obstetrics and Gynecology Consulting Physician

Vanderbilt University School of Medicine
Nashville, Tennessee
1993-1997, Medical Degree

Yukon-Kuskokwim Delta Regional Hospital
Bethel, Alaska
October 1996-December 1996, Medical school elective in Obstetrics and Gynecology

Harvard University
Cambridge, Massachusetts
1989-1993, A.B. in Biochemistry, *magna cum laude*

AWARDS AND HONORS

Women and Infants' Hospital
Chief Administrative Resident: June 2000-Present
Medical Student Teaching Pin: June 1998, June 2000
Berlix Award for Resident Education: June 1999
Best Resident Performance on CREOG Examination: June 1999

Vanderbilt University School of Medicine
Alpha Omega Alpha Medical Honor Society: Elected 1995, President 1996-1997
Canby Robinson Scholar: 1993-1997
Student Representative, Medical School Admissions Committee: 1994-1995
Diabetes Research and Training Center Summer Fellowship: 1994

Harvard University
John Harvard Scholarship: 1992-1993
Harvard College Scholarship: 1989-1992
Varsity Letter, Softball: 1990, 1991
Award for Excellence in Germanic Languages (German Consulate of Boston): 1991
Adelson Book Award for Excellence in Expository Writing: 1990

CERTIFICATION AND LICENSURE

Active Unrestricted Rhode Island License
USMLE/NBME Parts 1, 2 and 3 certified
Board Eligible, Obstetrics and Gynecology, June 2001

PROFESSIONAL SOCIETIES

American College of Obstetricians and Gynecologists, Junior Fellow: 1997-Present
Alpha Omega Alpha Medical Honor Society: 1995-Present

RESEARCH EXPERIENCE

"Evaluation of the Endocervical Canal: Can the Sleeved Cytobrush Replace the Endocervical Curette?" Preceptor: Dr. Lori A. Boardman, Department of Obstetrics and Gynecology, Women and Infants' Hospital. April 2000-Present.

"The Effect of Acute Endotoxin Infusion on Hepatic Carbohydrate Metabolism." Preceptor: Dr. Owen McGuinness, Department of Physiology and Molecular Biology, Vanderbilt University. June 1995- January 1996.

"The Effect of Chronic Norepinephrine Infusion on Hepatic Glucose Metabolism in the Conscious Dog." Preceptor: Dr. Owen McGuinness, Department of Physiology and Molecular Biology, Vanderbilt University. January 1995- June 1995.

PUBLICATIONS

Meinz H, Lacy DB, Ejiofor J, McGuinness OP. 1998. Alterations in hepatic gluconeogenic amino acid uptake and gluconeogenesis in the endotoxin treated conscious dog. *Shock*; 9(4): 296-303.

Meinz, Heidi. "Switzerland, Liechtenstein and Eastern Austria." In: **Let's Go: Europe 1992** and **Let's Go: Germany, Austria, Switzerland 1992**. Harvard Student Agencies, 1992.

PERSONAL

[redacted]

REFERENCES

Available upon request

APR 1 7 2001

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: (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) N
Please list ABMS Board Specialty:_____

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

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

License #: 11180

File #: 12193

☐ Home Address

HEIDI L MEINZ, MD

[redacted]

☒ Work Address

150 TARRYTOWN RD

MANCHESTER, NH 03103-2767
Phone: 603*622-3162

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

NONE

_____

_____

_____

_____

(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.

Khadi I M MD
Signature of Licensee (Signature Stamp Not Accepted)

April 11, 2001
Date

MAR 1 3 2002

#17599

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: 6/30/2003

Renewal Fee: $150.00

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

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

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

Specialty: OBG

Board Certified: (Y/N) N

Please list ABMS Board Specialty: _____

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

RI

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

License #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

Phone: 603*622-3162

☐ Home Address

[redacted]

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

~~NONE~~ Elliot Hospital

Catholic Medical Center

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied or have you surrendered a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated for use or misuse of any chemical substance?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding?	___	✓
9. Have any hospital privileges been suspended, limited, or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

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

Linda M

Signature of Licensee (Signature Stamp Not Accepted)

3/5/02

Date

MAR 2 0 2003

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#19145

For expiration on: 06/30/05

Renewal Fee: $300.00 ad
of 900

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

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

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

Specialty: OBG

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

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

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

License #: 11180

File #: 12193

☑ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

Phone: 603*622-3162

☐ Home Address

[redacted]

Phone: [redacted]

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

ELLIOT HOSPITAL, MANCHESTER, NH - ~~CATHOLIC MEDICAL CTR~~, MANCHESTER NH voluntarily gave up privileges so we could focus our attention on our Elliot privileges

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 12 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding?	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	✓	___

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

Signature of Licensee (Signature Stamp Not Accepted)

3/3/03
Date

MAR 23 2005

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

#22114

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) N

Please list ABMS Board Specialty: OB-GYN

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

~~MA~~ NH

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

License #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

Phone: 603*622-3162
Business Fax Number:
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
ELLIOT HOSPITAL	MANCHESTER	NH		☑	☐	☐
• Catholic Medical Center	Man.	NH		☐	☒	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction, or agreement for any reason, including rehabilitation by a licensing board?	___	✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?	___	✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding?	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	[redacted]	✓

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

Signature of Licensee (Signature Stamp Not Accepted)

03-16-05
Date

MAR 2 8 2007

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RECEIVED
MAR 2 6 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.) NH

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

License #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

Phone: 603*622-3162
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
ELLIOT HOSPITAL	MANCHESTER	NH		☑	☐	☐
CATHOLIC MED CTR	MANCHESTER	NH		☐	☑	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. Have you been subject to any disciplinary action, limitation, restriction or agreement for any reason, including rehabilitation, by a licensing board?		✓
2. Have you been denied, or have you surrendered, a license in any state other than for relocation or retirement?		✓
3. Have you been subject to any denial, restriction, suspension or loss/revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony or misdemeanor that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	✓	
8. Have you been the subject of an investigation or disciplinary proceeding? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form	✓✓	✓

[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 PERJURY THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE.

Signature of Licensee (Signature Stamp Not Accepted)

3/7/07
Date

APR 0 7 2009

RECEIVED
APR 0 3 2009
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6934

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

RENEWAL APPLICATION

For expiration on: 06/30/2011

Renewal Fee: $300.00 #29126

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

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

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

Specialty: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NONE 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 #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

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

☐ 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
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☐	☐
CATHOLIC MED CTR	MANCHESTER	NH	☐	☑	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

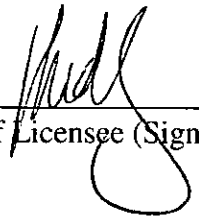
(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	✓
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?	___	✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?	___	✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?	___	✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?	___	✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?	___	✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.	___	✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	___	✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?	___	✓
10. Have any medical malpractice claims been made against you? See attached reporting form.	___	✓

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

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



Signature of Licensee (Signature Stamp Not Accepted) _____ Date

APR 14 2011

RECEIVED

APR 11 2011

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: 06/30/2013

Renewal Fee: $300.00

For Office Use Only:
Date Pd: 4/11/11 Check # 31803

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

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

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

Specialty: OBG

Currently Board Certified? (Y/N) Y

Please list ABMS Board Specialty: OBG

Currently licensed in the states of: (2 letter state abbrev.) NONE (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 #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

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

☐ Home Address

Phone [redacted]

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

Hospital			Privilege Full	Courtesy	Consult
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☐	☐
CATHOLIC MED CTR	MANCHESTER	NH	☐	☑	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

In the past 24 months:	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied, or have you surrendered or allowed to lapse, a license to practice medicine in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your DEA certificate?		✓
4. Have you been treated, other than through the Physician Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.	✓ (re. #10 only)	~~✓~~
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.**

[signature] 4/4/11

Signature of Licensee (Signature Stamp Not Accepted) Date

MAY 23 2013

RECEIVED
MAY 22 2013
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: 6/30/2015

Renewal Fee: $350.00

For Office Use Only:
Date Pd: 5/22/13 Check # 34435

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 [redacted] any change in address within 30 days of the change.**

Specialty: OBG

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

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

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

License #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

☐ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603*622-3162
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			Privilege	Full	Courtesy	Consult
ELLIOT HOSPITAL	MANCHESTER	NH		☑	☐	☐
~~CATHOLIC MED CTR~~	~~MANCHESTER~~	~~NH~~		☐	☑	☐
				■	■	■
				■	■	■
				■	■	■
				■	■	■
				■	■	■

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

[redacted]
Signature of Licensee (Signature Stamp Not Accepted)

3/26/13
Date

ABO+G

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

May 13, 2013

Heidi L. Meinz, MD
[redacted]

Dear Doctor:

Congratulations! I am pleased to inform you that you have satisfactorily completed the 2013 Maintenance of Certification assignments. You have earned 25 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 May 13, 2013 is "active" through 12/31/2014. 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 2014 MOC process will be available through your ABOG Member Login page beginning in November, 2013 .

Sincerely yours,

Kenneth Noller, M.D.
Director of Evaluation

KLN

ABOG ID: 9005112

MAR 19 2015 RECEIVED
MAR 18 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

Renewal Fee: $350.00

For expiration on: 6/30/2017

For Office Use Only: Date Pd: 3/18/15 Check # 36614

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

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

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

Specialty: OBG

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

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

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

License #: 11180

File #: 12193

☒ Work Address
HEIDI L MEINZ, MD
150 TARRYTOWN RD
MANCHESTER, NH 03103-2767

other location:
77 Gilcreast Rd
Suite 1000
Londonderry, NH
03053

☐ Home Address
[redacted]

Please provide current Email, Fax and Phone Numbers below:

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

Phone: 603-472-3146

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

Hospital Privileges			Full	Courtesy	Consult	Other
ELLIOT HOSPITAL	MANCHESTER	NH	☑	☐	☐	☐
			■	■	■	■
			■	■	■	■
			■	■	■	■
			■	■	■	■
			■	■	■	■
			■	■	■	■

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

xxt

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?	___	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 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. Have you completed the New Hampshire Department of Health and Human Services, Division of Public Health's Physician Licensure Survey?	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 N.H. Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted) — Date: 3/6/15

APR 3 2017

RECEIVED
MAR 22 2017
NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

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

RENEWAL APPLICATION

Renewal Fee: $350.00

For Office Use Only: Date Pd: 3/17 Check # 39064

For expiration on: 6/30/2019

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

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

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

Specialty: OBG

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

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

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

License #: 11180

File #: 12193

☒ Work Address

HEIDI L MEINZ, MD
150 TARRYTOWN RD

MANCHESTER, NH 03103-2767

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

☐ Home Address

[redacted]

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: [redacted]

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

Hospital Privileges

ELLIOT HOSPITAL MANCHESTER NH

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?	___	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 Expiration Date: BH8549529 exp 10/31/2018	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 of Licensee (Signature Stamp Not Accepted)

3/13/17
Date

Additional Location:

77 Gilcreast Rd

Suite 1000

Londonderry, NH 03053

(603) 622-3162

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

March 31, 2017

RE: Certification Status of Heidi L. Meinz, MD

To Whom It May Concern:

Heidi L. Meinz, MD is a Diplomate of the American Board of Obstetrics & Gynecology (ABOG).

Obstetrics and Gynecology Certification

ABOG ID Number: 9005112
Original Certification Date: 1/9/2004
Certification Status: Valid through: 12/31/2018
Participating in Maintenance of Certification: Yes

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

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

Sincerely,

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

A484712