PHYSICIAN ASSISTANT LICENSURE

censure Application ___X___

50.00 application fee ___X___

hours pharmacology ___X___ (not required until 3/1/94 if applying based on Route #3)

sciplinary inquiry ___X___

cense verifications ___—___ _____ _____

e-professional anscript(s) (BA gree or higher) ___X___

ysician assistant anscript ___X___

CPA certification assed exam & current) ___✓___

Letter(s) verifying CT employment 12/31/85 to present _____

NCCPA certification _____ (passed exam no later than 12/31/82 & current

Letter(s) verifying CT employment 1/1/91 to present _____

Letter(s) verifying employment x 18 yrs - at least 10 yrs in CT _____

NCCPA certification _____ (passed exam no later than 12/31/82)

NCCPA certification current as of 3-1-94 _____

TEMPORARY PERMIT

mporary Permit Application ___X___

5.00 application fee ___X___

censure application ___X___

50.00 application fee ___X___

hours pharmacology ___X___

ysician assistant transcript ___X___

e-professional transcript(s) A degree or higher) ___✓___

TE ISSUED TEMPORARY PERMIT _____

TE OF EXPIRATION OF PERMIT _____

56V

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

DECEMBER 22, 1995

SARAH F WHALEN
167 W BROAD STREET
PAWCATUCK, CT 06379

DEAR CANDIDATE:

On behalf of the Department of Public Health, I congratulate you upon the successful completion of all requirements for licensure as a Physician Assistant in the State of Connecticut.

Connecticut license 000534 has been issued to you, effective the date of this letter. Your actual license will be sent to you at a later date.

Please note that you may not legally practice until you have a clearly identified supervising physician who maintains the final responsibility for your performance and care of patients. Such supervising physician must be registered with the Department prior to your practice.

It is your responsibility to notify the Department of Public Health, Licensure and Registration Section, in writing, of any changes of name, residence address or business address, either within or outside Connecticut. Such notification to the Department of Public Health is required by law; failure to provide same may jeopardize the status of your license.

Failure to renew your license within ninety (90) days of the due date will result in your license becoming void. In that event, re-licensure would require a new application to the Department and a review of all credentials to determine whether you satisfy current licensing requirements. In order to avoid such a process, be sure that you renew your license in a timely manner each year in the month of your birth.

I wish you success in your career.

Respectfully,

Joseph J. Gillen, Ph.D.
Section Chief
Applications, Examinations and Licensure

JJG/cas
9575V

Phone: *TDD: 203-566-1279*
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

0000038

THIS CARD MUST BE COMPLETED AND RETURNED TO THE DEPARTMENT WITH YOUR LICENSE APPLICATION AND PAYMENT.

NOTE: "PLEASE DO NOT FOLD, BEND, SPINDLE OR MUTILATE THIS CARD"

NAME: Sarah F. Whalen

ADDRESS: _____

_____

PROFESSION: PHYSICIAN ASSISTANT TEMPORARY PERMIT

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE
150 WASHINGTON ST. HARTFORD, CT 06106

2200000023075001

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

APPLICATION FOR PHYSICIAN ASSISTANT LICENSURE
FEE: $150.00

INSTRUCTIONS - This application, together with the fee for $150.00 (Money Order or Certified Check) made payable to the Treasurer, State of Connecticut should be forwarded to Physician Assistant Licensure, Department of Public Health and Addiction Services, 150 Washington Street, Hartford, CT 06106. Please request all institutions or agencies providing supporting documents to forward same to this full address. ALL FEES ARE NON-REFUNDABLE!

NAME: WHALEN, SARAH FOX FOX
LAST FIRST MIDDLE MAIDEN

ADDRESS: 1438 S. Hanover St. Baltimore MD 21230 as of 6/15/95: 167 W. Broad St. B Pawcatuck, CT 06379
STREET CITY STATE ZIP

TELEPHONE NO.: (410) 685-1842 as of 6/15/95 (203) 599-8931
(Where you can be reached 8:30-4:30, M-F)

[redacted]
U.S. Social Security NO.

DATE OF BIRTH: 12/10/60 **PLACE OF BIRTH:** Waterville, ME

BACCALAUREATE EDUCATION:

NAME AND LOCATION OF ALL INSTITUTIONS ATTENDED	DATES ATTENDED	DEGREE AWARDED
Colby College Waterville, ME	9/78 - 5/82	B.A.

PROFESSIONAL EDUCATION:

NAME AND LOCATION OF PHYSICIAN ASSISTANT PROGRAM(S)	DATES ATTENDED
Essex Community College Baltimore, MD	9/93 - 6/95

WORK EXPERIENCE

LIST ALL WORK EXPERIENCE AS A PHYSICIAN ASSISTANT	EXACT DATES
N.A.	

9417V1/ Phone:

Have you passed the certification examination of the National Commission on Certification of Physician Assistants (NCCPA)? _____ Date passed? _____ will take examination 10/95

Are you currently certified by the NCCPA? NO

Have you completed at least sixty hours of didactic instruction in pharmacology for physician assistant practice? Yes

Do you hold a baccalaureate or higher degree in any field? Yes

Have you been employed since December 31, 1985, as a physician assistant in Connecticut, with no lapse of such employment of longer than twelve consecutive months? No

Have you been employed in Connecticut since not later than January 1, 1991, and have been employed for at least eighteen years as a physician assistant with no lapse of such employment of longer than twelve months and not less than ten years of such employment were in Connecticut? NO

Are you now or have you ever been licensed in any state? NO If so, please list all.

STATEMENT OF PROFESSIONAL HISTORY

Please answer each question below. If you answer yes to any question, please refer to attached instructions.

	YES	NO
1. Have you ever been censured, disciplined, dismissed or expelled from, had admissions monitored or restricted, had privileges limited, suspended or terminated, been put on probation, or been requested to resign or withdraw from any of the following: -Any hospital, nursing home, clinic, or similar institution; -Any health maintenance organization, professional partnership, corporation, or similar health practice organization, either private or public; -Any professional school, clinical clerkship, internship, externship, preceptorship, or postgraduate training program; -Any third party reimbursement program, whether governmental or private?	___	No
2. Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?	___	No
3. Has any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction, limited, restricted, suspended, or revoked any professional license, certificate, or registration granted to you, or imposed a fine or reprimand, or taken any other disciplinary action against you?	___	No
4. Have you ever, in anticipation or during the pendency of an investigation or other disciplinary proceeding, voluntarily surrendered any professional license, certificate, or registration issued to you by any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction?	___	No

5. Have you ever been subject to, or do you currently have pending, any complaint, investigation, charge, or disciplinary action by any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, or a foreign jurisdiction or any disciplinary board/committee of any branch of the armed services? You need not report any complaints dismissed as without merit. ___ No

6. Have you ever entered into, or do you currently have pending, a consent agreement of any kind, whether oral or written, with any professional licensing or disciplinary body in any state, the District of Columbia, a United States possession or territory, any branch of the armed services or a foreign jurisdiction? ___ No

7. Have you ever been found guilty or convicted as a result of an act which constitutes a felony under the laws of this state, federal law or the laws of another jurisdiction and which, if committed within this state, would have constituted a felony under the laws of this state? ___ No

8. Have you ever been denied or surrendered a state or federal controlled substance registration, had it revoked or restricted in any way, or been warned, reprimanded, or fined by the responsible agency? ___ No

Pursuant to Public Law 100-93, the Federal Government requires all states to report disciplinary actions to the Inspector General for Health and Human Services or risk losing Federal medicaid contributions. Although the disclosure of your social security number on this application is voluntary, Public Law 100-93 also requires the Department of Public Health and Addiction Services to request the disclosure of your number as data that would then be available to the National Practitioner Data Bank in the event that disciplinary action should be taken against your Connecticut license. You are not required by any law to disclose your social security number, but should you decide to do so, it will be used for identification purposes only, including verifying and retrieving information.

[redacted]

type
2") here
tos

must overlap photo

All of the above statements contained herein are true and correct to the best of my knowledge and belief

Sarah F. Whalen Date 5/17/95
Signature of Applicant

State of Maryland)
County Baltimore) ss

On this 18th day of May 1995, Sarah F. Whalen (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the photograph attached hereto is a true picture of self and that the statements made herein are true in every respect.

Sarah F. Whalen
Signature of Applicant

Sworn to before me this 18th day of May 1995.

Barbara P. Truszkowski
Signature of Notary Public
BARBARA P. TRUSZKOWSKI

NOTARY PUBLIC BALTIMORE COUNTY, MD.

My Commission expires 3-1-99.

1. If your answer is "yes", give full details, names, addresses, etc. on separate notarized statement.
2. If your answer is "yes", give names of professional society or association, date and reasons your membership or certification was suspended or revoked on a separate notarized statement.
3. If your answer is "yes", give full details, names, addresses, etc. on a separate notarized statement.
4. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
5. If your answer is "yes" give full details, names, addresses, etc. on a separate notarized statement.
6. If your answer is "yes" give full details on a separate notarized statement and submit notarized copy of agreement.
7. If your answer is "yes" give full details on a separate notarized statement and furnish a Certified Court Copy (with court seal affixed) of the original complaint, the answer, the judgement, the settlement, and/or the disposition of the case.
8. If your answer is "yes", give full details, dates, etc. on a separate notarized statement.

9417V/9

STATE OF CONNECTICUT

DEPARTMENT OF REVENUE SERVICES

ALLAN A. CRYSTAL
COMMISSIONER

October 1993

Dear Licensee:

As part of the process of assuring the fair and equitable sharing of the state tax burden, the 1993 General Assembly passed An Act Concerning the Disclosure of Information Maintained by Public Agencies to the Commissioner of Revenue Services and the Discouragement of Tax Evasion by Nonresident Construction Contractors Working at Connecticut Construction Sites (Public Act 93-228).

This bill requires all state agencies who issue licenses and permits to collect the licensee's federal employer identification number or social security number, and provide the Department of Revenue Services with this information. The Department will utilize this information in the administration and collection of state taxes.

Thank you for your cooperation in this matter.

Very truly yours,

A A Crystal

Allan A. Crystal
Commissioner of Revenue Services

Taxpayer Information; 1-800-321-7829 or 566-8520

DEAR LICENSURE APPLICANT:

PLEASE RECORD, IN THE APPROPRIATE SPACES, YOUR SOCIAL SECURITY NUMBER (SS#) AND/OR YOUR FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN).

SS# [redacted]

FEIN _ _ _ _ _ _ _ _ _

IF YOU DO NOT PROVIDE AT LEAST ONE OF THE ABOVE NUMBERS, PLEASE INDICATE THE REASON FOR NOT REPORTING BY PLACING A CHECK MARK IN THE APPROPRIATE SPACE BELOW:

1. ___ **SS/FEIN APPLICATION PENDING**
2. ___ **RESIDENT ALIEN**
3. ___ **NON-U.S. RESIDENT**
4. ___ **OTHER (EXPLAIN)** _____

_____

_____

THIS CARD MUST BE COMPLETED AND RETURNED TO THE DEPARTMENT
WITH YOUR LICENSE APPLICATION AND PAYMENT.

NOTE: "PLEASE DO NOT FOLD, BEND, SPINDLE OR MUTILATE THIS CARD"

NAME: Sarah F. Whalen

ADDRESS: _____

_____

PROFESSION: PHYSICIAN ASSISTANT

STATE OF CONNECTICUT
PARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
DIVISION OF MEDICAL QUALITY ASSURANCE
150 WASHINGTON ST. HARTFORD, CT 06106

1100000023150001

STATE OF CONNECTICUT

DEPARTMENT OF REVENUE SERVICES

ALLAN A. CRYSTAL
COMMISSIONER

October 1993

Dear Licensee:

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Very truly yours,

A A Crystal

Allan A. Crystal
Commissioner of Revenue Services

Taxpayer Information; 1-800-321-7829 or 566-8520

DEAR LICENSURE APPLICANT:

PLEASE RECORD, IN THE APPROPRIATE SPACES, YOUR SOCIAL SECURITY NUMBER (SS#) AND/OR YOUR FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN).

SS# [redacted]

FEIN _ _ _ _ _ _ _ _ _

IF YOU DO NOT PROVIDE AT LEAST ONE OF THE ABOVE NUMBERS, PLEASE INDICATE THE REASON FOR NOT REPORTING BY PLACING A CHECK MARK IN THE APPROPRIATE SPACE BELOW:

1. ___ **SS/FEIN APPLICATION PENDING**
2. ___ **RESIDENT ALIEN**
3. ___ **NON-U.S. RESIDENT**
4. ___ **OTHER (EXPLAIN)** _____

_____

_____

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE
PHYSICIAN ASSISTANT

Applicant: Please complete and sign this inquiry form and forward it to the Federation of State Medical Boards, 6000 Western Place, Suite 707, Fort Worth, TX 76102-7199.

RECEIVED
MAY 26 1995
By

DISCIPLINARY INQUIRY

The Connecticut Department of Public Health and Addiction Services requests a disciplinary search concerning the following individual:

WHALEN, SARAH FOX B.A., P.A. (Physician Assistant)
NAME (Last, First, Middle) **(Degree)**

1438 S. Hanover St.
ADDRESS

Baltimore, MD 21230
CITY, STATE AND ZIP CODE

60/12/10
DATE OF BIRTH (yy/mm/dd)

[redacted]
SOCIAL SECURITY NUMBER

Essex Community College Baltimore, MD
PHYSICIAN ASSISTANT SCHOOL OF GRADUATION
(Include complete name and branch location)

6/4/95
DATE OF GRADUATION

Please mail the response to the following address:

Department of Public Health and Addiction Services
Physician Assistant Licensure
150 Washington Street
Hartford, CT 06106

WE HAVE NO UNFAVORABLE INFORMATION REGARDING THE ABOVE NAMED PHYSICIAN
JUN 01 1995
James R. Winn, M.D.
JAMES R. WINN, M.D.
EXECUTIVE VICE-PRESIDENT

Sarah F. Whalen
APPLICANT SIGNATURE

9417V/14

Phone:
TDD: (203) 566-1279
150 Washington Street • Hartford, CT 06106
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

Physician Assistant Licensure

Verification of Pharmacology Coursework

Applicant: Please complete the top portion of this form and forward to the educational institution, post-graduate program provider, NCCPA or American Academy of Physician Assistants for official verification of completion of pharmacology instruction for physician assistant practice.

Name of Applicant: Sarah F. Whalen

Date of birth: 12 / 10 / 60
mo day yr

Identification information if required by verifying entity (e.g., certification number): _____

****

The applicant listed above is applying for physician assistant licensure in Connecticut. Please provide the following information regarding pharmacology instruction in the physician assistant educational program or in a post-graduate program for physician assistant practice.

Did this individual receive at least sixty (60) hours of didactic instruction in pharmacology for physician assistant practice? yes X **no** _____ **If no, how many hours did this individual receive?** _____

Where was such instruction completed? Essex CC PA Program

Dates of candidate's attendance: from Sept 93 **to** June 95

If in a post-graduate program, was the coursework Category I approved CME? N/A
Who was the approval body (i.e. AAPA, AMA, AAFP, ACCME)?

Did the candidate satisfactorily complete this coursework? _____

Comment: _____

Signature of Authorized Representative
Donna Sewell
Director
Title

May 22, 1995
Date
Physician Assistant Program
Essex Community College
Organization

Thank you for your assistance. **Please return this form directly to:**
Physician Assistant Licensure
Department of Public Health and Addiction Services
150 Washington Street
Hartford, CT 06106

9417V/12

ESSEX COMMUNITY COLLEGE

Division of Allied Health

April 28, 1995

To Whom It May Concern:

Sarah Whalen will graduate from the Essex Community College Physician Assistant Program on June 4, 1995. The program included 60 hours of formal pharmacology instruction.

Sincerely,

Donna Sewell
Director
Physician Assistant Program

7201 Rossville Boulevard, Baltimore County, Maryland 21237-3899

NATIONAL COMMISSION ON CERTIFICATION OF PHYSICIAN ASSISTANTS, INC.
2845 HENDERSON MILL ROAD, N.E.
ATLANTA, GEORGIA 30341
(770) 493-9100

DECEMBER 13, 1995

TO: DEPT. OF PUBLIC HEALTH AND
ADDICTION SERVICES
PHYSICIAN ASST. LICENSURE
150 WASHINGTON STREET
HARTFORD, CT 06106

RE: SARAH F. WHALEN, PA-C

TO WHOM IT MAY CONCERN:

IT IS AFFIRMED THAT THE ABOVE-REFERENCED INDIVIDUAL SUCCESSFULLY COMPLETED THE PHYSICIAN ASSISTANT NATIONAL CERTIFYING EXAMINATION ADMINISTERED OCTOBER 13, 1995, AND WAS GRANTED NCCPA CERTIFICATE NO. 960197 ON DECEMBER 08, 1995.

THE STATUS OF CERTIFICATE NO. 960197 IS CURRENT AND IN GOOD STANDING UNTIL JUNE 1, 1998.

YOURS TRULY,

Lucille L. Cate

LUCILLE L. CATE
DIRECTOR OF ADMINISTRATIVE SERVICES

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

DIVISION OF MEDICAL QUALITY ASSURANCE

APPLICATION FOR PHYSICIAN ASSISTANT TEMPORARY PERMIT

FEE: $75.00

Recent graduates may apply for a temporary permit which authorizes them to practice as a physician assistant only in those settings where the supervising physician is physically present on the premises and is immediately available to the physician assistant when needed. The temporary permit does not authorize the holder to prescribe or dispense drugs and shall be valid only until the issuance of the results of the first certification examination scheduled by the NCCPA following the applicants' graduation from an accredited physician assistant program. The temporary permit is NOT RENEWABLE. Individuals who do not successfully complete the examination, or who do not attend the examination, cannot be issued a new temporary permit.

INSTRUCTIONS - This application, together with the fee for $75.00 (Money Order or Certified Check) made payable to the Treasurer, State of Connecticut should be forwarded to Physician Assistant Licensure, Department of Public Health and Addiction Services, 150 Washington Street, Hartford, CT 06106. The temporary permit application fee must be submitted separate from the licensure application fee. ALL FEES ARE NON-REFUNDABLE

NAME: WHALEN (LAST) SARAH (FIRST) F. (MIDDLE) FOX (MAIDEN)

ADDRESS: as of 6/15 167 W. Broad St. Pawcatuck, CT. 06379
1438 S. Hanover St. (STREET) Baltimore (CITY) MD (STATE) 21230 (ZIP)

TELEPHONE NO.: (410) 685-1842 as of 6/15 (203) 599-8931
(Where you can be reached 8:30-4:30,M-F)

[redacted] **U.S. SOCIAL SECURITY NO.**

DATE OF BIRTH: 12/10/60 **PLACE OF BIRTH:** Waterville, ME.

Have you ever taken the certification examination of the National Commission on Certification of Physician Assistants (NCCPA)? YES _____ NO ✓

If yes - What was the date of examination? _____

If no - What is the date when the examination will be taken? 10/95

What is the name of the physician who will supervise your work under the temporary permit? I will contact you with this name as soon as it is available

9417V/1C

Pursuant to Public Law 100-93, the Federal Government requires all states to report disciplinary actions to the Inspector General for Health and Human Services or risk losing Federal medicaid contributions. Although the disclosure of your social security number on this application is voluntary, Public Law 100-93 also requires the Department of Public Health and Addiction Services to request the disclosure of your number as data that would then be available to the National Practitioner Data Bank in the event that disciplinary action should be taken against your Connecticut license. You are not required by any law to disclose your social security number, but should you decide to do so, it will be used for identification purposes only, including verifying and retrieving information.

All of the above statements contained herein are true and correct to the best of my knowledge and belief

Sarah F. Whalen — 5/17/95

Signature of Applicant — Date

State of Maryland)
County Baltimore) ss

On this 18th day of May 1995, Sarah F. Whalen (applicant's name) personally appeared before me, who being duly sworn says that she/he is the person referred to in the foregoing application and that the statements made herein are true in every respect.

Sarah F. Whalen
Signature of Applicant

Sworn to before me this 18th day of May 1995.

Barbara P. Truszkowski
Signature of Notary Public
BARBARA P. TRUSZKOWSKI NOTARY PUBLIC BALTIMORE COUNTY

My Commission expires 3-1-99.

9417V/||

STATE OF CONNECTICUT - DEPARTMENT OF HEALTH SERVICES
PHYSICIAN ASSISTANT
VERIFICATION OF LICENSE OR CERTIFICATION

N.A.

Applicant - Complete the top portion of this form and forward it to each state where you have been/are licensed or certified as a physician assistant (make copies as necessary).

Name: _____
Last First Middle Maiden

Address: _____
No. & Street City State Zip

Physician Assistant Program Completed at: _____
Name of School & Location

Original License/Certification Number _____ Date Issued: _____
(in this state)

I hereby authorize the _____ to furnish the Connecticut Department of Public Health and Addiction Services the information requested below.

Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE -- FOR LICENSING AGENCY USE ONLY

This is to certify that the above named individual was issued license/certification number _____

To Practice as a Physician Assistant on: _____
(date of issuance)

Current Licensure Status: Active _____
Inactive _____
Lapsed _____

Date License Expires: _____

Has this license/certification ever been encumbered in any way (revoked, suspended, surrendered, restricted, limited, or placed on probation or is the license/certification currently the subject of an investigation or pending disciplinary action?) YES ___NO ___
If yes, please forward all publicly disclosable information regarding the encumbrance and the basis for same. Please advise this office if you require a consent for release of this information from the applicant.

SEAL Signed: _____ Title: _____

State: _____ Date: _____

PLEASE COMPLETE AND RETURN DIRECTLY TO:
PHYSICIAN ASSISTANT LICENSURE
DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES
150 WASHINGTON STREET
HARTFORD, CT 06106

9417V/13

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH AND ADDICTION SERVICES

BUREAU OF HEALTH SYSTEM REGULATION

PHYSICIAN ASSISTANT TEMPORARY PERMIT

INSTRUCTIONS:

1. Part I of this form is to be completed by the supervising physician.
2. The form is to be returned to Physician Assistant Licensure, Department of Public Health and Addiction Services.
3. The form will be signed and sealed and returned to the applicant by the Department.
4. A new permit will be required in the event of a change of supervising physician.

****

PART I: To be completed by the supervising physician

Name: Dr. Robert Crootof

Office Address
(where physician assistant will function): Planned Parenthood of CT
12 Case St. Norwich CT
06360

Telephone No. (203) 889-5211 License No. 015328

I certify that I am registered with the Department of Public Health and Addiction Services to be a supervising physician pursuant to Section 20-12c and am employed in the setting where the temporary permittee will be employed. I understand that I must be physically present on the premises when the temporary permittee engages in physician assistant activities, and must be immediately available to the physician assistant when needed. I further understand that I must notify the Department in writing within thirty days in the event of termination of this physician-physician assistant supervisory relationship.

Robert E Crootof, MD — 8/2/95

Signature of Supervising Physician — Date

****

PART II: To be completed by the Department of Public Health and Addiction Services

This is to certify that Sarah Whalen having satisfied the requirements specified in section 20-12b(d), is issued a Temporary Permit, to practice as a physician assistant only in those settings where the supervising physician is physically present on the premises and is immediately available to the physician assistant when needed. The temporary permit does not authorize the holder to prescribe or dispense drugs.

Date of Issue of Temporary Permit: 8/14/95

Date of Expiration of Permit: 2/28/96 or upon notification of failure of examination, if prior to this date.

Signed: Joseph J. Gillen

Joseph J. Gillen, Ph.D.
Section Chief
Examinations, Applications & Licensure

(203) 566-1284

Not Valid Unless Affixed With Department of Public Health and Addiction Services Seal

9498V/cas

Phone: TDD: 203-566-1279
150 Washington Street — Hartford, CT 06106
An Equal Opportunity Employer

ESSEX COMMUNITY COLLEGE

Division of Allied Health

June 7, 1995

Physician Assistant Licensure
State of Connecticut
Department of Public Works
150 Washington Street
Hartford, CT 06106

To Whom It May Concern:

This is to verify that **Sarah F. Whalen,** attended the Essex Community College Physician Assistant Program from September 1993 through May 1995 and graduated in good standing on June 4, 1995.

If any addition information is required, please do not hesitate to contact me.

Sincerely,

Donna Sewell, M.S., PA-C
Director
Physician Assistant Program
780-6579

DS:sas

Renewal - 23.000534

Name	SARAH F WHALEN PA
Credential	23.000534

Fee Details

Renewal Application Fee	$155.00
	$155.00

Demographic Information-Renewal

1. Please provide your Date of Birth
   12/10/1960

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

5. Street Address
   45 Franklin St

6. Unit/Apartment Number

7. City
   New London

8. State (two letter abbreviation)
   CT

9. Zip Code
   06320

National Commission Certification on Certification of Physician Assistants

10. Do you hold current certification by the National Commission on Certification of Physician Assistants?
    Yes

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

11. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
    1407936875

Current Work Force Status

12. What is your current work status in your licensed profession?
Full-time (30 hours or more per week)

Practice Location

Please identify the location of the primary site where you spend the most time in the practice of your profession.

13. Address 1
45 Franklin St

14. Address 2

15. City
New London

16. State
CT

17. Zip Code
06320

Attestation

18. Within the last year, have you been convicted of a felony?
No

19. If yes, please provide details here

20. Within the last year, have you had any disciplinary action taken against you or any such actions pending by another State's licensing/certification authority?
No

21. If yes, please provide details here

22. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license including maintaining certification by the National Commission on Certification of Physician Assistants.**
12/21/2017

Review

Important Note

To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.

Renewal - 23.000534

Name	SARAH F WHALEN PA
Credential	23.000534

Fee Details

Renewal Application Fee	$155.00
	$155.00

Demographic Information-Renewal

1. Please provide your Date of Birth
   12/10/1960

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

Residence Address

Please enter the information below regarding the address of your residence. Please note that entering your address here will not change your mailing address in our system. If you have a change of address, please email it to oplc.dph@ct.gov. For your protection, please include your profession, license number and the last 4 digits of your SSN in your request.

5. Street Address
   32 West Beach St.

6. Unit/Apartment Number

7. City
   Westerly

8. State (two letter abbreviation)
   RI

9. Zip Code
   02891

National Commission Certification on Certification of Physician Assistants

10. Do you hold current certification by the National Commission on Certification of Physician Assistants?
    Yes

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

11. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
    1407936875

Current Work Force Status

12. What is your current work status in your licensed profession?
Full-time (30 hours or more per week)

Practice Location

Please identify the location of the primary site where you spend the most time in the practice of your profession.

13. Address 1
45 Franklin ST

14. Address 2

15. City
Westerly

16. State
RI

17. Zip Code
02891

Attestation

18. Within the last year, have you been convicted of a felony?
No

19. If yes, please provide details here

20. Within the last year, have you had any disciplinary action taken against you or any such actions pending by any State, federal government jurisdiction, District of Columbia, United States possession or territory or foreign jurisdiction?s licensing/certification authority?
No

21. If yes, please provide details here

22. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license including maintaining certification by the National Commission on Certification of Physician Assistants.**
10/01/2018

Review

Important Note

To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.

Renewal - 23.000534

Name	SARAH F WHALEN PA
Credential	23.000534

Fee Details

Renewal Application Fee	$155.00
	$155.00

Demographic Information-Renewal

1. Please provide your Date of Birth
   12/10/1960

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   White

Address

5. Please update any changes to your mailing address:

Address 1: 45 FRANKLIN ST

Address 2:

City: NEW LONDON **State:** CT **Zip Code:** 06320 **Country:** UNITED STATES

6. Please update any changes to your primary address:

Address 1: 45 FRANKLIN ST

Address 2:

City: NEW LONDON **State:** CT **Zip Code:** 06320 **Country:** UNITED STATES

Telephone Number: (860) 443-5820

National Commission Certification on Certification of Physician Assistants

7. Do you hold current certification by the National Commission on Certification of Physician Assistants?
   Yes

National Provider Identifier

The National Provider Identifier (NPI) is a 10-digit identifier required on all HIPAA standard electronic transactions. NPIs have replaced all separately issued identifiers, including Medicaid PINs and Medicare UPINs, on HIPAA standard electronic transactions. In the past, health plans assigned an identifying number to each provider with whom they conducted electronic business. Since providers typically work with several health plans, they were likely to have a different identification number for each plan. The NPI has been put in place so that each provider has one unique, United States federal government-issued identifier to be used in transactions with all health plans with which the provider conducts business.

8. Please enter your NPI number here (if you do not know your NPI number, you may retrieve it at https://npiregistry.cms.hhs.gov.) If you do not have an NPI number, please enter ten (10) zeros):
   1407936875

Current Work Force Status

9. What is your current work status in your licensed profession?
Full-time (30 hours or more per week)

Practice Location

Please identify the location of the primary site where you spend the most time in the practice of your profession.

10. Address 1
45 Franklin st New London CT

11. Address 2

12. City
New London

13. State
CT

14. Zip Code
02891

Attestation

15. Since your last renewal, have you been convicted of a felony?
No

16. If yes, please provide details here

17. Since your last renewal, have you had any disciplinary action taken against you or any such actions pending by any State, federal government jurisdiction, District of Columbia, United States possession or territory or foreign jurisdictions licensing/certification authority?
No

18. If yes, please provide details here

19. **By completing this renewal online, I verify that all the information I have provided is accurate and that I satisfy the renewal requirements that apply to my license including maintaining certification by the National Commission on Certification of Physician Assistants.**
12/14/2019

Review

Important Note

To continue processing your transaction, please click "Add to Invoice" on the NEXT screen (read the rest of this information first).

On the top right of the invoice screen, select **"Pay Invoice".**

PLEASE NOTE THAT WHEN ENTERING YOUR CREDIT CARD NUMBER, DO NOT ENTER SPACES OR DASHES AS IT WILL RESULT IN A FAILED TRANSACTION.

Thank you for processing your application online.