Application - Physician/Surgeon

Name	CHRISTOPHER DENAPOLES
Credential	Physician/Surgeon

Fee Details

Fee to Query NPDB	$4.75
Initial Application Fee	$565.00
	$569.75

Application Instructions

Thank you for applying for your license online. Please note that as part of this application, you will be required to upload a recent picture of yourself. Please make sure you have one available on the device you are using to file this application.

Please note that you need to arrange for the submission, directly from the source, of a transcript from your medical school, verification of at least 2 years of progressive, post graduate residency training, verification of completion of the required examinations and verification of all licenses held, current or expired.

Applicants who completed medical school outside of the United States are required to arrange for their medical school to send a completed school verification form and a transcript directly to this office verifying completion of medical school. Non-US trained applicants are also required to arrange for the submission of verification of current certification by ECFMG.

For detailed information regarding eligibility and documentation requirements, please visit www.ct.gov/dph/license and select Physician/Surgeon.

As part of this application, you will provide information that will be used to create a profile that will be published on the Department's website. Following issuance of licensure, you will be provided with an opportunity to review and update the profile prior to its publication.

APPLICANTS WHO HAVE HELD A CT PHYSICIAN LICENSE IN THE PAST SHOULD NOT USE THIS SERVICE TO APPLY FOR REINSTATEMENT.

Demographic Information - Initial App

7. Maiden Name
   DeNapoles

1. Please provide your Date of Birth
   01/02/1986

2. U.S. [redacted]

3. Gender
   Male

4. Race:
   White

5. Ethnicity: Please choose one
   Not Hispanic or Latino

6. Please attach a recent photo of the applicant.
   [redacted]

Basis of Licensure

Please select a basis for licensure.

Please note the following definitions:

Endorsement: Select this basis of licensure if you were educated in the United States and are, or have been, licensed in any other U.S. state or Canadian province.

Endorsement - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and you are, or

have been, licensed in any U.S. state or Canadian province.

Exam: Select this basis of licensure if you were educated in the U.S. and this is the first time you are applying for a license in any jurisdiction.

Exam - FT: Select this basis of licensure if you completed your educational preparation outside of the U.S. and this is the first time you are applying for a license in any jurisdiction.

8. Select Basis for Licensure
Exam-FT

Federation Credentials Verification Service (FCVS)

FCVS obtains primary-source verification of medical education, postgraduate training, examination history, board action history, board certification and identity. This repository of information allows a physician and/or physician assistant to establish a confidential, lifetime professional portfolio with FCVS which can be forwarded, at the applicant's request, to any state medical and osteopathic board that has established an agreement with FCVS. Please note that this is optional.

9. If you plan to use the Federation Credentials Verification Service (FCVS) to verify your core credentials, enter your FCVS Packet ID here

Medical Education

10. Medical School
Trinity School of Medicine

11. Year of Graduation
2013

Post Graduate Training Information

Please enter any internship, residency or fellowship training you have completed

12. List your postgraduate training:

Site Name	City	State	Country	Start Date	End Date	Level	Type
Stamford Hospital	STAMFORD	Connecticut	UNITED STATES	07/01/2013	06/30/2017	Resident	Family Medicine

Specialty/Board Certification

Please enter your specialty, subspecialty and indicate the date on which you were certified by an ABMS ABMOS specialty board

13. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS.

Specialty	Subspecialty		Certifying Board	Certification Date
Family Medicine	Subspecialty	Certification Date		

Other State License

14. Indicate states outside of CT where licenses are held, current or expired

State	Disciplinary Action

Current Practice Information

15. Upon issuance of your Connecticut license, will you practice medicine in Connecticut?
No

16. Are you actively involved in patient care?
Yes

17. Enter your practice locations

				City	State			

Practice Name	Address 1	Address 2	Address 3			Zip Code	Primary Practice	Languages Spoken at this Location

Connecticut Hospitals and Nursing Home Privileges

Please enter the Connecticut hospitals and nursing homes where you will have admitting privileges

18. Indicate the Connecticut hospitals or nursing homes for which you have staff privileges

Facility Name	City	State
Stamford Hospital	Stamford	Connecticut

Medical Education Responsibilities

21. Are you a member of the faculty of a Connecticut medical school?
No

20. Select the state medical schools at which you are a member of the faculty.

19. Do you have current responsibility for graduate medical education?
Yes

Statement of Professional History

Please answer the following questions. If you answer yes to any of the questions regarding your professional history, please provide details in the space available below and arrange for the submission of supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review. Applicant's answering affirmatively to any question below may be contacted for additional information.

22. 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

23. 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

24. 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

29. 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

25. 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

26. 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

27. 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

28. Provide details regarding any question(s) above that you may have answered affirmatively.

Medical Malpractice Payment History

Please indicate below any malpractice payments that you have made or have been made on your behalf during the ten (10) year period immediately preceding the date of this application

30. Indicate your malpractice insurance carrier:

31. Indicate the medical malpractice payments that have been made by you or on your behalf within the past ten years.

Resolved Date	Payment Category	Amount Paid	Specialty	Group Count	Payment Count

Felony Conviction History

Please list any felony that you have been convicted of during the ten (10) year period immediately preceding the date of this application

32. Please enter any felony convictions within the previous ten years.

Conviction Date	Conviction

Hospital Discipline

Please list any disciplinary action taken against you by a hospital during the ten (10) year period immediately preceding the date of this application

33. Please enter any felony convictions within the previous ten years.

Conviction Date	Conviction

Publications, Services or Awards

Please indicate any publications, services or awards (this section is voluntary)

34. In this section, you may add any publications, professional services, activities, and awards that you would think useful to viewers of your profile.

Publisher/Issuer	Title/Award Name	Date

Application Attestation

35. By filing this application online on the date indicated below, I attest that I am the person referred to in this application and that the photograph attached hereto is a true picture of me and that the statements made herein are true in every respect.
07/11/2016

Review