Renewal - 1.054532

Name	SETUL R PARDANANI
Credential	1.054532

Fee Details

Renewal Application Fee	$575.00
	$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
   07/04/1973

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Asian

Email Address Verification

Please be advised that in the future, the Department will no longer be mailing hardcopy renewal notices. Rather, renewal notices will be sent via email. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

5. By entering a date in this field, I confirm that I will verify that the Department has my correct email address on file.
   05/16/2016

Medical Education

6. Medical School
   Albert Einstein College of Medicine

7. Year of Graduation
   1999

Specialty/Board Certification

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

Specialty	Subspecialty	Certifying Board	

				Certification Date
Obstetrics and Gynecology	**Subspecialty**	**Certification Date**	American Board of Obstetrics and Gynecology	11/11/2005

Current Workforce Status in Medicine

9. What is your current work status in Medicine?
Full Time - (40 hours or more per week)

10. In the next 12 months, do you plan to (please mark all that apply):
None

11. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
Educator/Faculty
Administrator/Manager

12. If your response to the previous question was other, please enter additional comments here.

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.

13. 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):
1851471338

Physician Renewal Practice Location

14. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Stamford Hospital	30 Shelbourne Rd			Stamford	Connecticut	06902	No	

15. Approximately how many physicians are associated with your practice?
12

16. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
No

17. Please select the best choice for the type of ownership of your practice.
Hospital

Practice Ownership - Organization

18. Please enter the name of the organization/person that owns the practice where you work.
Stamford Hospital

19. City
Stamford

20. State (two letter abbreviation)
CT

New Patients

21. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

22. Are you accepting new patients covered by:
Both

Primary Source of Payment

What percent of your patients have the following source of Payment?

23. Medicare
less than 10%

24. Medicaid
26 - 50%

25. Self-Pay
26 - 50%

26. Private Insurance
less than 10%

27. Other
None

28. Does your practice offer sliding fee scale based on ability to pay?
Yes

29. Approximately what percentage of your patients use sliding fee schedules?
26-50%

Populations Served

Please approximate the percentage of patients at your primary practice location that are:

30. Homeless
11-25%

31. Migrant/Seasonal Farm Workers
None

32. Native Americans
Less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

33. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
05/16/2016

Fee

Pursuant to Public Act 15-5, the Connecticut General Assembly passed legislation that increased license renewal fees by $5.00. The additional $5.00 fee is allocated for services provided by the Health Assistance InterVention Education Network (HAVEN), a confidential program designed to assist qualifying health care practitioners who suffer from chemical dependency, emotional or behavioral disorders, or physical or mental illness to maintain their license while receiving the support necessary to practice safely and effectively. To learn more about HAVEN, please visit their website at http://www.haven-ct.org/.

Physician Attestation

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

35. If yes, please provide details here

36. 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

37. If yes, please provide details here

38. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

39. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
05/16/2016

Important Note

To continue processing your renewal, please click "Next" below (read the rest of this information first).

On the review screen, click **"Add to Invoice."**

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.

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Review

Renewal - 1.054532

Name	SETUL R PARDANANI
Credential	1.054532

Fee Details

Renewal Application Fee	$575.00
	$575.00

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Demographic Information-Renewal

1. Please provide your Date of Birth
   07/04/1973

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Asian

Email Address Verification

Please be advised that the Department will no longer be mailing hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date. After you complete this transaction, please select the 'My Account' link at the top right of the homepage and make sure that your email address on file is correct. If it is not correct, please update it. Thank you.

5. By entering a date in this field, I confirm that I will verify that the Department has my correct email address on file.
   07/03/2017

Medical Education

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   Albert Einstein College of Medicine

7. Year of Graduation
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Specialty/Board Certification

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

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Current Workforce Status in Medicine

9. What is your current work status in medicine?
Full Time - (40 hours or more per week)

10. In the next 12 months, do you plan to (please mark all that apply):
None

11. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:

12. If your response to the previous question was other, please enter additional comments here.

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1851471338

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15. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
15

16. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
Yes

17. Please select the best choice for the type of ownership of your practice.
Hospital

Practice Ownership - Organization

18. Please enter the name of the organization/person that owns the practice where you work.
Stamford Hospital

19. City
Stamford

20. State (two letter abbreviation)
CT

New Patients

21. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

22. Are you accepting new patients covered by:
Both

Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

23. Medicare
less than 10%

24. Medicaid
26 - 50%

25. Self-Pay
51 - 75%

26. Private Insurance
less than 10%

27. Other
None

28. Does your practice offer sliding fee scale based on ability to pay?
Yes

29. Approximately what percentage of your patients use sliding fee schedules?
26-50%

Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

30. Homeless
Less than 10%

31. Migrant/Seasonal Farm Workers
Less than 10%

32. Native Americans
None

Connecticut Prescription Monitoring and Reporting System

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After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

33. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
07/03/2017

Physician Attestation

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

35. If yes, please provide details here

36. 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

37. If yes, please provide details here

38. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

39. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
07/03/2017

American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians' licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of one's own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Important Note

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

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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 renewal online.

Review

Renewal - 1.054532

Name	SETUL R PARDANANI
Credential	1.054532

Fee Details

Renewal Application Fee	$575.00
	$575.00

Workforce Survey Introduction

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Demographic Information-Renewal

1. Please provide your Date of Birth
   07/04/1973

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Asian

Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

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
   27 Bowman Dr

6. Unit/Apartment Number

7. City
   Greenwich

8. State (two letter abbreviation)

CT

9. Zip Code
06831

Medical Education

10. Medical School
Albert Einstein College of Medicine

11. Year of Graduation
1999

Specialty/Board Certification

12. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	**Subspecialty**	**Certification Date**	American Board of Obstetrics and Gynecology	11/11/2005

Current Workforce Status in Medicine

13. What is your current work status in medicine?
Full Time - (40 hours or more per week)

14. In the next 12 months, do you plan to (please mark all that apply):
None

15. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
Educator/Faculty

16. If your response to the previous question was other, please enter additional comments here.

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.

17. 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):
1851471338

Physician Renewal Practice Location

18. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Stamford Hospital	30 Shelbourne Rd			Stamford	Connecticut	06902	No	

19. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
3

20. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
Yes

21. Please select the best choice for the type of ownership of your practice.
Hospital

Practice Ownership - Organization

22. Please enter the name of the organization/person that owns the practice where you work.
Stamford Hospital

23. City
Stamford

24. State (two letter abbreviation)
CT

New Patients

25. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

26. Are you accepting new patients covered by:
Both

Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

27. Medicare
11 - 25%

28. Medicaid
11 - 25%

29. Self-Pay
51 - 75%

30. Private Insurance
less than 10%

31. Other
None

32. Does your practice offer sliding fee scale based on ability to pay?
Yes

33. Approximately what percentage of your patients use sliding fee schedules?
51-75%

Populations Served

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Please approximate the percentage of patients at your primary practice location that are:

34. Homeless
Less than 10%

35. Migrant/Seasonal Farm Workers
Less than 10%

36. Native Americans
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37. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
06/11/2018

Physician Attestation

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

39. If yes, please provide details here

40. 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

41. If yes, please provide details here

42. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
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06/11/2018

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Review

Renewal - 1.054532

Name	SETUL R PARDANANI
Credential	1.054532

Fee Details

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Demographic Information-Renewal

1. Please provide your Date of Birth
   07/04/1973

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Asian

Address

5. Please update any changes to your mailing address:

   Address 1: 27 BOWMAN DR

   Address 2:

   City: GREENWICH **State:** CT **Zip Code:** 06831 **Country:** UNITED STATES

6. Please update any changes to your primary address:

   Address 1: 1 hospital plaza

   Address 2:

   City: STAMFORD **State:** CT **Zip Code:** 06904 **Country:** UNITED STATES

Telephone Number: (203) 276-7581

Email Address Verification

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7. Street Address
   27 Bowman Drive

8. Unit/Apartment Number

9. City
   Greenwich

10. State (two letter abbreviation)
    CT

11. Zip Code
    06831

Medical Education

12. Medical School
    Albert Einstein College of Medicine

13. Year of Graduation
    1999

Specialty/Board Certification

14. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

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    Full Time - (40 hours or more per week)

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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.

19. 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):
1851471338

Professional Liability Insurance

Your professional practice act requires that a practitioner providing direct patient care services must maintain professional liability insurance or other indemnity against liability for professional malpractice. You may find information regarding professional liability insurance requirements by selecting this **link** and choosing your profession from the list.

Physician Renewal Practice Location

20. Please indicate the name and address of your primary practice location as well as languages spoken at that location. Please note that you can add additional practice locations but you may only select one (1) primary practice location.

Practice Name	Address 1	Address 2	Address 3	City	State	Zip Code	Primary Practice	Languages Spoken at this Location
Stamford Hospital	30 Shelbourne Rd			Stamford	Connecticut	06902	No	

21. Approximately how many physicians are associated with your practice (If you are in residency training, please enter zero (0) here)?
2

22. Is the primary site where you spend most time providing direct patient care a JCAHO/NCQA recognized patient care centered medical home?
Yes

23. Please select the best choice for the type of ownership of your practice.
Hospital

Practice Ownership - Organization

24. Please enter the name of the organization/person that owns the practice where you work.
Stamford Hospital and Optimus Health Center

25. City
Stamford

26. State (two letter abbreviation)
CT

New Patients

27. Please select the best response that describes your patient care practice status:
I can accept some new patients; my practice is far from full

28. Are you accepting new patients covered by:
Both

Primary Source of Payment

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

What percent of your patients have the following source of payment?

29. Medicare
less than 10%

30. Medicaid
26 - 50%

31. Self-Pay
26 - 50%

32. Private Insurance
less than 10%

33. Other
None

34. Does your practice offer sliding fee scale based on ability to pay?
Yes

35. Approximately what percentage of your patients use sliding fee schedules?
51-75%

Populations Served

Please answer the questions to the best of your ability. If you do not know the exact amount, please select the answer that you think is correct. This information is used by the Department to analyze current trends in the practice of medicine in Connecticut and is not used in any way to determine your eligibility for license renewal.

Please approximate the percentage of patients at your primary practice location that are:

36. Homeless
11-25%

37. Migrant/Seasonal Farm Workers
Less than 10%

38. Native Americans
Less than 10%

Connecticut Prescription Monitoring and Reporting System

All prescribing practitioners possessing a Connecticut controlled substance registration (CSP) issued by the Connecticut Department of Consumer Protection (DCP) must register with the Connecticut Prescription Monitoring and Reporting System (CPMRS) online at www.ctpmp.com.

After you have completed this renewal transaction, please visit the DCP's website at www.ct.gov/dcp and select 'Programs & Services' then 'Prescription Monitoring Program' for information regarding registration.

39. I acknowledge that I have read the information regarding registration in the Connecticut Prescription Monitoring and Reporting System.
07/23/2019

Physician Attestation

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

41. If yes, please provide details here

42. 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

43. If yes, please provide details here

44. I attest that I am in compliance with the mandatory continuing education requirements and that I am in compliance with the mandatory professional liability insurance coverage requirements.
Yes

45. I attest that on this date I completed this renewal application online and that all of the statements made by me on this renewal are accurate.
07/23/2019

American Medical Association's Opinions

The Connecticut Medical Examining Board and the Connecticut Department of Public Health encourage you to read the following opinions of the American Medical Association's Code of Medical Ethics related to common reasons for discipline on Connecticut physicians licenses.

AMA Code of Ethics

Opinion 1.2.1 Treating Self or Family

Treating oneself or a member of ones own family poses several challenges for physicians, including concerns about professional objectivity, patient autonomy, and informed consent.

When the patient is an immediate family member, the physician's personal feelings may unduly influence his or her professional medical judgment. Or the physician may fail to probe sensitive areas when taking the medical history or to perform intimate parts of the physical examination. Physicians may feel obligated to provide care for family members despite feeling uncomfortable doing so. They may also be inclined to treat problems that are beyond their expertise or training.

Similarly, patients may feel uncomfortable receiving care from a family member. A patient may be reluctant to disclose sensitive information or undergo an intimate examination when the physician is an immediate family member. This discomfort may particularly be the case when the patient is a minor child, who may not feel free to refuse care from a parent.

In general, physicians should not treat themselves or members of their own families. However, it may be acceptable to do so in limited circumstances:

(a) In emergency settings or isolated settings where there is no other qualified physician available. In such situations, physicians should not hesitate to treat themselves or family members until another physician becomes available.

(b) For short-term, minor problems.

When treating self or family members, physicians have a further responsibility to:

(c) Document treatment or care provided and convey relevant information to the patient's primary care physician.

(d) Recognize that if tensions develop in the professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

(e) Avoid providing sensitive or intimate care especially for a minor patient who is uncomfortable being treated by a family member.

(f) Recognize that family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician.

AMA Principles of Medical Ethics

Opinion 9.1.1 Romantic or Sexual Relationships wth Patients

Romantic or sexual interactions between physicians and patients that occur concurrently with the patient physician relationship are unethical. Such interactions detract from the goals of the patient-physician relationship and may exploit the vulnerability of the patient, compromise the physician's ability to make objective judgments about the patient's health care, and ultimately be detrimental to the patient's well-being.

A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient.

Likewise, sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship, or if a romantic relationship would otherwise foreseeably harm the individual.

In keeping with a physician's ethical obligations to avoid inappropriate behavior, a physician who has reason to believe that

nonsexual, nonclinical contact with a patient may be perceived as or may lead to romantic or sexual contact should avoid such contact.

Important Note

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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.

Review

Renewal - 1.054532

Name	SETUL R PARDANANI
Credential	1.054532

Fee Details

Renewal Fee	$575.00
	$575.00

Workforce Survey Introduction

Dear Licensee:

Thank you for renewing your license online.

As part of this renewal application, you will be asked to enter your National Provider Identification (NPI) number. Please make sure you have that information available before proceeding. If you do not have your NPI number with you, you can find it online at https://npiregistry.cms.hhs.gov/. You will also be asked to enter information regarding your practice location, specialty and patients served.

The purpose of the questions is to allow the Department of Public Health to collect valuable workforce and patient care data that is critical in identifying and addressing healthcare workforce shortage and patient care issues.

Thank you for assisting the Department in this important initiative.

Demographic Information-Renewal

1. Please provide your Date of Birth
   07/04/1973

2. Gender
   Female

3. Ethnicity: Please choose one
   Not Hispanic or Latino

4. Race:
   Asian

Address

5. Please update any changes to your mailing address:

   Address 1: 27 BOWMAN DR

   Address 2:

   City: GREENWICH **State:** CT **Zip Code:** 06831 **Country:** UNITED STATES

6. Please update any changes to your primary address:

   Address 1: 1 hospital plaza

   Address 2:

   City: STAMFORD **State:** CT **Zip Code:** 06904 **Country:** UNITED STATES

Telephone Number: (203) 276-7581

Email Address Verification

Please be advised that the Department no longer mails hardcopy licenses and renewal notices. Rather, licenses and renewal notices will be sent via email. You will receive an electronic copy of your license via email within a few days of completing this transaction. Renewal notices will be sent via email approximately 60 days prior to your license expiration date.

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.

7. Street Address
   27 Bowman Drive

8. Unit/Apartment Number

9. City
   Greenwich

10. State (two letter abbreviation)
    CT

11. Zip Code
    06831

Medical Education

12. Medical School
    Albert Einstein College of Medicine

13. Year of Graduation
    1999

Specialty/Board Certification

14. Please indicate practice specialties, subspecialties and the date you were certified by ABMS or ABOMS, if applicable. Board certification is not a requirement for licensure.

Specialty	Subspecialty		Certifying Board	Certification Date
Obstetrics and Gynecology	Subspecialty	Certification Date	American Board of Obstetrics and Gynecology	11/11/2005

Current Workforce Status in Medicine

15. What is your current work status in medicine?
    Full Time - (40 hours or more per week)

16. In the next 12 months, do you plan to (please mark all that apply):
    None

17. If 100% of your primary professional position is not direct patient care, please indicate which of the following apply:
    Educator/Faculty

18. If your response to the previous question was other, please enter additional comments here.

National Provider Identifier

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3

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Practice Ownership - Organization

24. Please enter the name of the organization/person that owns the practice where you work.
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25. City
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New Patients

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07/22/2020

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Thank you for processing your application online.

Review

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
Physician Licensing
Email: dph.healingarts@ct.gov
Website: www.ct.gov/dph/license

Physician License Application

[redacted]

REC'D MAY 1 5

END

☑ MD ☐ DO Please check (✓) one

This application must be accompanied by **2 checks**: one [illegible] **4.75** payable to ***"Treasurer, State of Connecticut."***

➔ **Return completed application and fee to:**

CT DPH, Physician Licensing Application Process[illegible], PO Box 340308, Hartford, CT 06134

First Name		Maiden Name	Social Security Number
SETUL	R PARDANANI		[redacted]

Email Address	Street Address	City	State	Postal Code
setul.pardanani@gmail.com	15 Canterbury Dr	GREENWICH	CT	06831

Telephone Number		Date of Birth	Ethnicity: check (✓)
203 532 5102	☐ Male ☑ Female	07/04/1973	☐ Hispanic or Latino ☑ Not Hispanic or Latino

Race: Please check (✓) all that apply

☐ American Indian or Alaska Native ☑ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Have you held a Connecticut physician license in the past? NO ☐ Yes ☑ No Lic. No.

Are you now or have you ever been licensed as a physician in any state? If yes, please list all (please abbreviate):
NY

Do you plan to use the Federation Credentials Verification Service (FCVS) to verify your credentials? ☑ Yes ☐ No Packet ID No. 338333

Please indicate the examination you completed in order to qualify for licensure:

☑ United States Medical Licensing Examination ☐ Federation Licensing Examination ☐ National Board of Medical Examiners
☐ Licentiate of the Medical Council of Canada ☐ State Board Exam ☐ National Board of Osteopathic Examiners
☐ Combination of Segments (please specify): _____

Upon issuance of your license, will you practice medicine in Connecticut? ☑ Yes ☐ No

Will you be actively involved in patient care? ☑ Yes ☐ No

Please indicate the name of your malpractice insurance carrier: Health Star Indemnity Company LTD

Name of primary practice location where you will practice in Connecticut	Address	City	Postal Code
Stamford Hospital	30 Shelburne Rd	Stamford	06902

Please list the languages, other than English, that are spoken at this location: _____

Please list Connecticut hospitals where you have or will have admitting privileges:
Stamford Hospital

Medical School Name/Country: Albert Einstein College of Medicine, NY Year of Graduation: 1999

Please list the following information regarding all of your post-graduate training:

Site, City and State	Date Start	Date End	Training Level (Intern, Resident, Fellow)	Training Type (Internal Medicine, Surgery, etc)
Montefiore Medical Center Bronx, NY	7/1999	6/2000	Intern	Obstetrics & Gynecology
Montefiore Medical Center, Bronx NY	7/2000	6/2003	Resident	Obstetrics & Gynecology

Please indicate your specialty area: OB/Gyn Subspecialty:

Are you certified by an ABMS or ABOMS Board? ☑ Yes ☐ No

If yes, please indicate name of Board: American Board of OB/Gyn Date Certified: 2005

Publications, professional services, activities/awards (**this section is voluntary**) Please include a maximum of ten (10) entries in this section.

Publication/Entity Issuing Award	Title of Article/Award	Date Published/Awarded

Are you/will you be a member of the faculty of a Connecticut medical school?	☐ Yes ☑ No	☐ Quinnipiac University ☐ University of Connecticut School of Medicine ☐ Yale University School of Medicine

Do you/will you have current responsibility for graduate medical education in Connecticut? ☑ Yes ☐ No

Please list any **revocation or restriction of hospital privileges** for reasons related to competence or quality of patient care that has been taken by a hospital's governing body or any other official of the hospital after procedural due process has been afforded. Also include the resignation from or the non-renewal of medical staff privileges or the restriction of privileges at a hospital during the course of an investigation. Please list only those that have occurred within the past ten (10) years.

Hospital, City and State	Date	Description

Please list **medical malpractice court judgments and all medical malpractice arbitration awards** in which a payment was awarded to a complaining party in the last ten (10) years in any state that you have held an active license. Also list all settlements of malpractice claims in which a payment was made to a complaining third party in the last ten years in any state in which you have held an active license.

Date Resolved	Amount Paid	Practice Specialty Payment Related To

Please list any **felony convictions** in any state within the last ten (10) years. For the purpose of this section a person shall be deemed to be convicted of a crime if the licensee plead guilty or was found or adjudged guilty by a court of competent jurisdiction or has been convicted of a felony by the entry of a plea of nolo contendere in any state.

Date of Conviction	Conviction

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?	☐ Yes ☑ No
Have you ever had your membership in or certification by any professional society or association suspended or revoked for reasons related to professional practice?	☐ Yes ☑ No
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?	☐ Yes ☑ No
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?	☐ Yes ☑ No
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?	☐ Yes ☑ No
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?	☐ Yes ☑ No
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?	☐ Yes ☑ No

If you answered yes to any of the above questions regarding your professional history, please provide full details and provide supporting documentation (e.g. certified court copy with court seal affixed, complaint, answer, judgment, settlement or disposition) that will assist this office's review.

NOTARIZATION: On this 29th day of April 20 15, the above referenced individual 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 or any document attached hereto are true in every respect.

Sworn to before me this 29th day of April 20 15.

Signature of Applicant

Signature of Notary Public

My Commission Expires: _____

ANDREW JOHN HARTSMAN
NOTARY PUBLIC
State of Connecticut
My Commission Expires
June 30, 2018

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)

400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: Albert Einstein COM of Yeshiva University

Attention: **Program Director**

Specialty: Obstetrics and Gynecology

Affiliated University: **Yeshiva University**

Address: Bronx, NY

Verification For:

Name: Pardanani, Setul Ram

DOB: 07/04/1973

Individual's Name on Record (If different from above): _____

Program Participation:

Important:

Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: 1, 2, 3 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 07/01/1999 **To:** 06/30/2002
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: 4 (e.g., 1, 2, 3, etc.)
☐ Internship ☒ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: OB/GYN
From: 07/01/2002 **To:** 06/30/2003
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research

Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:

Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only)**.

Affix your institutional seal in this space. If no seal is available, you must have this verification notarized

ELECTRONIC SEAL VERIFIED

Name: Erika H Banks, MD

Signature: Erika H Banks, MD

Title of Signatory: Program Director (e.g., Program Director)

Date of Signature: 06/05/2015

Tel: 718-430-4031 Fax: 718-430-2576 E-Mail: ebanks@montefiore.org

Rev. 06/02/2015

FCVS ID: 338333 FID: 213731912 CODE: 100198

United States Medical Licensing Examination® (USMLE®)
Certified Transcript of Scores

This document was prepared by the
Federation of State Medical Boards of the United States, Inc.
Federation Place, 400 Fuller Wiser Road, Suite 300, Euless, TX 76039-3856 -- Telephone (817) 868-4000

Date : **06/15/2015**

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 338333

Examinee: Pardanani, Setul Ram
Alt Name(s):

Examinee ID#: 5-017-904-3
Date of Birth: 07/04/1973

Results for Steps taken by this examinee (and for which results have been reported to date) are shown below. For Steps that span more than one day, the test date reflects the day on which the examination began. Where numeric scores are reported, the recommended minimum passing score ("MP") is shown in parentheses. Pass/fail outcomes are based upon the minimum passing level in place at the time of test administration and are not altered by subsequent revisions to the minimum passing level. Effective April 1, 2013, test results are reported on a three-digit scale only; two-digit scores reported for prior administrations will no longer be reported. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale.

USMLE STEP 1

	Test Date	Pass/Fail	Total	MP	Comments
	06/10/1997	Pass	225	(176)	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	Total	MP	Comments
	08/25/1998	Pass	220	(170)	

USMLE STEP 3

	Test Date	Pass/Fail	Total	MP	Comments
NEW YORK	09/07/2001	Pass	190	(182)	

NOTE: A search of the Board Action Data Bank of the Federation of State Medical Boards (FSMB) reveals no reported information on this examinee.

Practitioner Profile for SETUL R PARDANANI, 1.054532 view pub update online

Practitioner Profile Status

Prepublication Status	None
Publication Status	Published
Pending Updates	YES

1. Physician Information update

License Number	54532
Effective Date	08/13/2015
Expiration Date	07/31/2021
Currently practicing medicine in CT	YES
Actively involved in patient care	YES
Malpractice Insurance Providers	Health Star Indemnity Company, LTD

Practice Locations add

	Practice	Address	Languages	Primary?
update	Stamford Hospital	30 Shelbourne Rd Stamford, CT 06902		NO

Staff Privileges add

	Facility	Address	Start Date	End Date
update	Stamford Hospital	Stamford, CT		

2. Medical School update

Medical School	Albert Einstein College of Medicine
Year of Graduation	1999

3. Post Graduate Training add

	Start	End	Type	Level	Hospital	Address
update	07/01/2000	06/30/2003	OB/GYN	Resident	Montefiore Medical Center	Bronx, NY UNITED STATES
update	07/01/1999	06/01/2000	OB/GYN	Intern	Montefiore Medical Center	Bronx, NY UNITED STATES

4. Specialty Area and Board Certification add

	Specialty/Subspecialty	Board Cert Date	Speciality End Date	Certifying Board
update	Obstetrics and Gynecology add sub	11/11/2005		American Board of Obstetrics and Gynecology

5. CT Medical Education Responsibility update

Member of faculty of a CT medical school	NO
Medical School	
Current Responsibility for graduate medical education	NO

6. Publications, Professional Services, Activities, Awards add

Publisher/Issuer	Title/Award Name	Date

7. Hospital Discipline add

Hospital	Address	Date	Discipline

8. Medical Malpractice Payments add dispute

Payment Date	Payment Category	Amount Paid	Related Practice Specialty

9. Felony Convictions add dispute

Date of Conviction	Conviction

10. CT Licensure Disciplinary Actions dispute

Date of Action	Action	License Status

Post Prepublication Post Publication