File # 17639

New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE. PLEASE PRINT.

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

Physician Name: Julie A. Johnston

N.H. License Number: 16515

Business Name: Joan G. Lovering Health Center

☐ Address: PO Box 456, 559 Portsmouth Ave
Greenland NH 03840-0456

Office telephone: (603) 436-7588

Business Fax Number: (603) 431-0451 Business E-Mail: mail@fhc-p.org

☐ Home Address: [redacted]

Home telephone: [redacted]

Specialty: Family Practice Board certified: Yes

Hospital affiliations: N/A

In what other states do you hold a current license: MA

New Hampshire Board of Medicine

121 SOUTH FRUIT STREET, SUITE 301, CONCORD, NH 03301-2412
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

March 5, 2014

JULIE A JOHNSTON MD
[redacted]

Dear Dr. Johnston:

Congratulations. The New Hampshire Board of Medicine has granted your application for licensure. Your license, numbered 16515 is dated March 5, 2014 and is enclosed with this letter.

You are required to renew your license on a biennial basis and forms for that purpose will be forwarded to you at the address on file with the Board in April of the year in which your renewal is set to occur. For this reason, a form is enclosed which should be returned to us if and when you change your home or business address. Please be aware that you are required to inform the Board of any change of address within 30 days of that change.

An engrossed certificate of licensure will be provided to you within the next six months. This certificate is for display purposes only and does not constitute a legal document which verifies current licensure. The enclosed pocket size card should be used for that purpose.

Please feel free to contact this office if you have any questions.

Sincerely,

Penny Taylor

Penny Taylor
Administrator

Encl.

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

PLEASE COMPLETE AND RETURN TO THE BOARD OF MEDICINE AS SOON AS POSSIBLE. PLEASE PRINT.

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

Physician Name: Julie Johnston, M.D.

N.H. License Number: T-0695

Business Name: Joan G. Lavering Health Center

☐ Address: P.O. box 456
559 Portsmouth Ave
Greenland, NH 03840 Office telephone: 603-436-7588

Business Fax Number: 603-431-0451 Business E-Mail: juliejohnston.md@gmail.com

☑ Home Address: [redacted]

Home telephone: [redacted]

Specialty: Family Medicine Board certified: yes 7/07 Family Medicine

Hospital affiliations: Lawrence General Hospital Lawrence, MA

In what other states do you hold a current license: MA

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

FP (BC)

The Warren Alpert Med Sch of Brown U. 2004

Medical Professional Information Profile

This report provides credentialing information for

Name: **Julie Ann Johnston**

Social Security Number: [redacted]

Date of Birth: [redacted], MD

FID#: [redacted]

Recipient: **NH - New Hampshire Board of Medicine**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Julie Ann Johnston**
Date of Birth:
Social Security Number:
FID:

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Valid Original Passport OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Michigan State University College of Human Medicine
1. Medical Education Form
2. Medical Education Transcript

The Warren Alpert Medical School of Brown University
1. Medical Education Form
2. Medical Education Dean's Letter
3. Medical Education Transcript
4. Medical Education Diploma

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

Greater Lawrence Family Health Center
1. GME Form
2. GME Completion Certificate

VI. Licensure Examination History

A. FSMB Exam Transcript

End of report for: Julie Ann Johnston

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Section I

FCVS Reports

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name: **Julie Ann Johnston**
Documentation: Valid Original Passport

Gender: Female
Date of Birth: [redacted]
Place of Birth:
Social Security Number: [redacted]
FID:
Physical Description: Height: [redacted]
Weight:
Eye Color:
Hair Color:

Contact Information

Mailing Address: [redacted]
UNITED STATES

Permanent Address: [redacted]
UNITED STATES

Telephone Numbers: Primary: [redacted]
Secondary: N/A
Fax: N/A
Other: N/A

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **University of Michigan Ann Arbor**
Address: Ann Arbor, MI 48109-1382
UNITED STATES
Dates of Attendance: 09/--/1995 To 05/--/1999
Degree Conferred/Issued: Bachelor of Science

ECFMG

There are none identified or not applicable.

Medical Education

Medical School: **Michigan State University College of Human Medicine**
Address: A-110 East Fee Hall
East Lansing, MI 48824
UNITED STATES

Dates of Attendance: 08/28/2000 to 06/24/2002
Date Certificate Issued: N/A
Degree Conferred/Issued: Did not receive degree

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Medical School: **The Warren Alpert Medical School of Brown University**
Address: Office of Student Affairs
97 Waterman Street Box G A2
Providence, RI 02912
UNITED STATES

Dates of Attendance: 07/01/2002 to 05/31/2004
Date Certificate Issued: 05/31/2004
Degree Conferred/Issued: Doctor of Medicine

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **Greater Lawrence Family Health Center**
Address: 34 Haverhill Street

Lawrence, MA 01841-2884
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Family Medicine
Dates of Attendance: 06/15/2004 To 06/16/2005
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 2
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 06/17/2005 To 06/18/2006
Completed Successfully: Yes
Accreditation: ACGME

Training Level: 3
Program Type: Residency
Specialty: Family Medicine
Dates of Attendance: 06/19/2006 To 06/22/2007
Completed Successfully: Yes
Accreditation: ACGME

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

FSMB Transcript USMLE Step 1	Date: 06/2002	Passed the Exam
FSMB Transcript USMLE Step 2	Date: 09/2003	Passed the Exam
FSMB Transcript USMLE Step 3	Date: 08/2006	Passed the Exam

ABMS Verification

A report of the result from a search of the data provided by the American Board of Medical Specialties is enclosed.

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: Julie Ann Johnston FID: [redacted]

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name: **Julie Ann Johnston**

Date of Birth: [redacted]

Social Security Number:

FID:

Omissions

There are no omissions identified.

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Discrepancies

There are no discrepancies identified.

Miscellaneous Information

There is no miscellaneous information identified.

End of report for: Julie Ann Johnston

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Julie Ann Johnston**
Date of Birth:
Social Security Number:
FID#:

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
09/2000	06/2002	Medical Education Record	Michigan State University College of Human Medicine,A-110 East Fee Hall East Lansing, MI 48824 UNITED STATES		
07/2002	05/2004	Medical Education Record	The Warren Alpert Medical School of Brown University,Office of Student Affairs Providence, RI 02912 UNITED STATES		
06/2004	06/2007	GME Record	Greater Lawrence Family Health Center,34 Haverhill Street Lawrence, MA 01841-2884 UNITED STATES		

End of report for: Julie Ann Johnston

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Section II

FSMB and Other Reports

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FPDC | FEDERATION PHYSICIAN DATA CENTER

Board Action Clearance Report

February 07, 2014

Attn:

Re: Board Action Query Dated: February 07, 2014
FSMB Batch Number: [redacted]

The following is a report of the search results from the Board Action Data Bank as of February 07, 2014 for practitioners submitted as part of the above-referenced batch for which NO board actions were identified.

Provider cleared with No Actions as of February 07, 2014

Name	DOB	School	Yr/Grad	Provider ID
Julie Ann Johnston	[redacted]	040010	2004	294365

License History

Licensing Entity
MAINE
MASSACHUSETTS
VERMONT

PLEASE NOTE: The licensure history information contained in these reports is not considered licensure verification but rather an indicator of known states of historical licensure for these individuals. Use of this information should be limited to cross-reference purposes.

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

ABMS Verification of Certification

Federation of STATE MEDICAL BOARDS

As of: **02/07/2014**
Medical Professional Name: **Julie A Johnston**
Date of Birth: [redacted]
Year of Graduation: **2004 (Doctor of Medicine)**
ABMSUID#: [redacted]

Certification

Certification:

Board: Family Practice
Specialty: Family Practice
Status: ACT
Initial Certification: 07/20/2007

End of report for Julie A Johnston

All certification information on the ABMS report is based on a search of data shared with the FSMB by the American Board of Medical Specialties. For some physicians the biographic data in the ABMS database is incomplete and is not included in the shared data. FCVS is unable to verify specialty certification on these physicians. FCVS does not follow up with the applicant or ABMS on any missing or discrepant information.

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Section III

Identity

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the "INSTRUCTIONS FOR COMPLETING THE FCVS APPLICATION" and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
The physician has been instructed to sign the front of the photograph. Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I, hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.

While the FSMB will only use collected personal information for the purposes described on our website and in the FCVS application materials, the FSMB has no control over the entities to which an applicant authorizes the release of FCVS materials. Such entities may include state medical boards, state osteopathic boards, and other entities that may be subject to state and federal public information or open records laws, which might require the release of certain FCVS packet information to the public upon request.

9/26/13

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

Johnston

Applicant's Printed Last Name

9/26/13

Date of Signature (must correspond to date of notarization)

State of MA, County of Essex

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 26th day of September, 2013.

Notary Public Signature:

My Notary Commission Expires: November 10, 2016

294365 214568438

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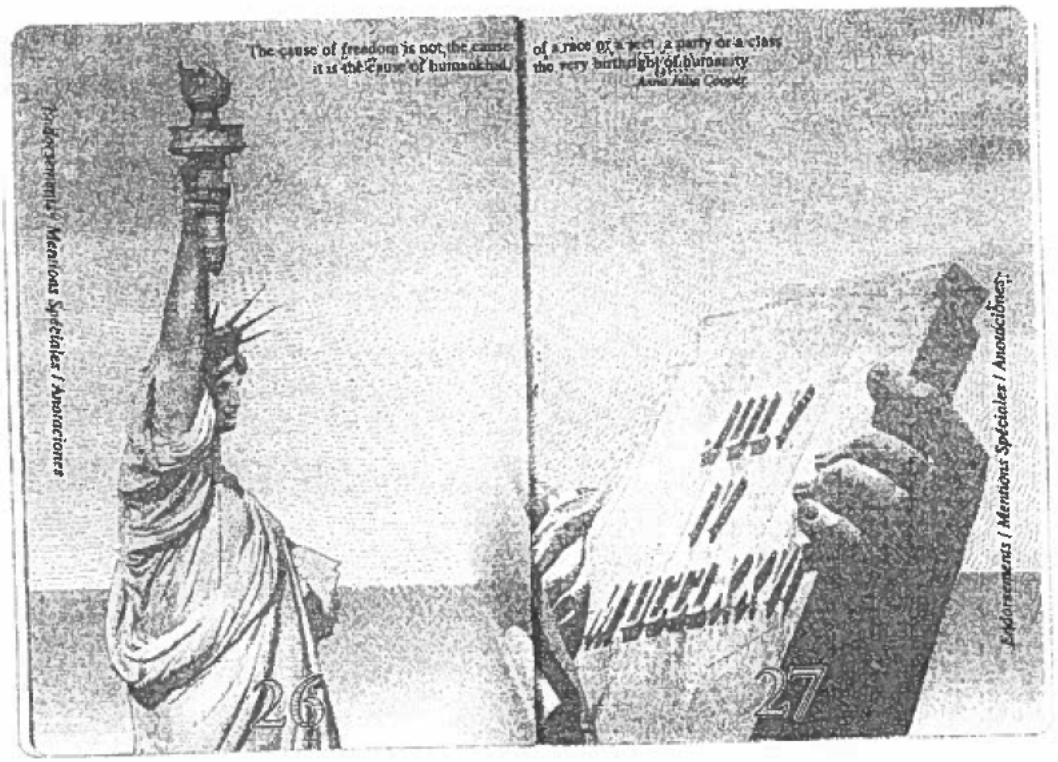
THE FEDERATION OF STATE MEDICAL BOARDS
MCMXII
UNITED STATES

The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

October 3, 2013

Date



The Federation Credentials Verification Service certifies that this page was copied directly from the original document.

Kevin Caldwell
Federation Credentials Verification Service

October 3, 2013

Date

Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Michigan State University College of Human Medicine

Address Line 1:
Life Sciences Building

Address Line 2:
1355 Bogue Street, Room A234

City: East Lansing **State/Province:** MI **Zip Code (Postal Code):** 48824
Country: US

If name of institution was different when this individual attended, please note this name below:

Premedical Education:
Years of education required for admission to your medical school: 4-year degree
Credential/degree presented by the applicant for admission to your medical school: 4-year degree

Enrollment and Participation: Our records indicate that Johnston, Julie Ann
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 77 weeks of medical education on the following dates: From: 8 28 00 (Month Day Year) To: 6 24 02 (Month Day Year)

This individual
Was awarded the degree of _____ on __/__/__ (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)
Student withdrew to transfer to another medical school.

Watermark
For FCVS internal use only.
SEAL VERIFIED

Name: Gina L. Brooks, M.A.
Signature: Gina L. Brooks
Title: College Records Officer
Date of Signature: 11/20/13 Phone: (517) 353-7140
Fax: (517) 353-7140 Email: brooksgi@msu.edu

294365 2943865 1045 1045 214568438

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? ___ YES X NO

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Health	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Financial	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved
Other	From (Mo/Yr)____/____	To (Mo/Yr)____/____	___ Approved	___ Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? ___ YES X NO

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

Academic Probation	From (Mo/Yr)____/____	To (Mo/Yr)____/____
Probation for unprofessional conduct/behavioral	From (Mo/Yr)____/____	To (Mo/Yr)____/____
Probation for other reason	From (Mo/Yr)____/____	To (Mo/Yr)____/____

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? ___ YES X NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? ___ YES X NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

___ YES X NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:

294365 294365 1045 214568438

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FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Julie Ann Johnston
Michigan State University College of Human Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Julie Ann Johnston

PROVIDED BY APPLICANT

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MICHIGAN STATE UNIVERSITY

OFFICIAL ACADEMIC TRANSCRIPT

PRINTED: 10/16/13
PAGE: 01 OF 01

JOHNSTON, JULIE ANN

STUDENT ID: [redacted]

COURSE	TITLE	CRS	GRADE	S/R	H
	PREVIOUS/TRANSFER INSTITUTIONS				
ONSTED COMMUNITY HIGH SCHOOL ONSTED MI	ATTENDED: 08/91 - 06/95				

[redacted]

SEAL VERIFIED

PROVIDED SOLELY FOR: (1)
FEDERATION CREDENTIA VERI ICATION
SERVICE I I A N
400 FULLER WISER ROAD
SUITE 300
EULESS TX 76039

Nicole G Royig
University Registrar

294/365
1045

THE FACE OF THIS TRANSCRIPT IS PRINTED WITH BLACK INK ON PAPER WITH GREEN BACKGROUND.

MICHIGAN STATE UNIVERSITY

Office of the Registrar
Hannah Administration Building
426 Auditorium Road, Room 150
East Lansing, MI 48824-0210
Telephone (517) 355-3300

This information is confidential. Its release is governed by the Family Education Rights and Privacy Act (FERPA) of 1974, as amended and the Michigan State University Access to Student Information policy. FERPA prohibits the release of this record or disclosure of its contents to any other party without written consent from the student.
Alteration of this transcript may be a criminal offense.

Accreditation

Michigan State University is a member of the Association of Public and Land-grant Universities, Association of American Universities, American Council on Education, American Council of Learned Societies, Association of Graduate Schools, Council of Graduate Schools, Committee on Institutional Cooperation, and International Association of Universities. The University has been accredited by the Higher Learning Commission of the North Central Association of Colleges and Schools, 30 North LaSalle Street, Chicago, Illinois 60602-2504, (312)263-0456, www.ncahigherlearningcommission.org. Some individual programs, schools, and colleges have been recognized by the accrediting agencies in their respective fields. For a list, visit www.opb.msu.edu, select "Strategic Planning" and then "Agencies that Accredit MSU."

Transcript Validation and Authenticity

A transcript is official when it bears the signature of the University Registrar and the University seal in black ink, is obtained directly from the Office of the Registrar at Michigan State University, and is received by the person for whom it is intended. All paper-copy transcripts will be printed with black ink on paper with a green background which repeats "MICHIGAN STATE UNIVERSITY" over the entire page.

Calendar

The University offers instruction throughout the year during the fall semester, spring semester and summer sessions. Academic calendars are available at www.reg.msu.edu.

Credits

Effective Fall 1992 courses at Michigan State University are offered on a semester basis. One credit is equivalent to one instructor-student contact hour per week per semester plus two hours of study per contact hour; OR two hours of laboratory contact hours per week per semester, plus one additional hour spent in report writing and study; or other combinations of contact and study hours which constitute an equivalent of these experiences. Prior to Fall 1992 courses at Michigan State University were offered on a quarter basis.

To convert to quarter credits, the semester credits should be multiplied by 3/2.

Course Numbering System

001-099 – Non-Credit and Institute of Agricultural Technology Courses
100-299 – Undergraduate Courses
300-499 – Advanced Undergraduate Courses
500-599 – Graduate Courses prior to 1960
500-699 – Graduate – Professional Courses
800-899 – Graduate Courses
900-999 – Advanced Graduate Courses

Honors

An "H" in the Honors column indicates an honors course, honors section of a course, or the student took a non-honors course as honors. The latter indicates additional work was completed beyond normal requirements.

Grading System

The minimum cumulative grade-point average required for graduation is a 2.0 for undergraduate students and 3.0 for graduate students.

The Numerical System: 4.0, 3.5, 3.0, 2.5, 2.0, 1.5, 1.0, 0.0 – Credit is awarded for the following minimum levels – 1.0 for undergraduate students and 2.0 for graduate students. However, all grades are counted in the calculation of the grade-point average.

The Credit-No Credit System: CR-CREDIT – Credit was granted and represents a level of performance equivalent to or above the grade-point average required for graduation. NC-NO CREDIT – No credit was granted and represents a level of performance below the grade-point average required for graduation.

The Pass-No Grade System: P-PASS – Credit was granted and the student achieved a level of performance judged to be satisfactory by the instructor. N-NO GRADE – No credit was granted and the student did not achieve a level of performance judged satisfactory by the instructor.

Other Symbols Used: W-WITHDREW; V-VISITOR; U–UNFINISHED, I-INCOMPLETE; DF-DEFERRED; ET-EXTENSION; NGR-NO GRADE REPORTED; CP-CONDITIONAL PASS; & LDR-LATE DROP.

Grading Systems prior to Fall 1988: Please visit www.reg.msu.edu/transcripts.

Grade Point Average (GPA)

To compute the grade-point average for a semester, multiply the numerical grade by the number of credits for the course to obtain the total grade points. Then divide the total grade points for the semester by the total credits for the semester.

The minimum grade-point average required for graduation is 2.0 for undergraduate students and 3.0 for graduate students.

Courses in which P, I, N, DF, W, ET, CP, CR, NC, U or V have been received do not affect the grade-point average.

Grade Point systems prior to Summer 1972: Please visit www.reg.msu.edu/transcripts.

Repeated Courses

A course repeated is indicated in one of two ways:

1. By an R (Repeat) to the right of the "Descriptive Title", or

2. by an R (Repeat) in the SR column. In this case, you will also see an S (Superseded) in the SR column indicating the course being repeated.

For both formats term credit and grade-point average (GPA) totals are not adjusted for repeats in the term of the superseded course. The summary totals for the level of the student are adjusted to include only the last entry.

Withdrawal

A withdrawal from the University occurs when a student drops all courses within a semester. A student may voluntarily withdraw from the University prior to the end of the twelfth week of a semester or within the first 6/7 of the duration of the student's enrollment in a non-standard term of instruction (calculated in weekdays). Withdrawal is not permitted after these deadlines.

Courses in which the student is enrolled are deleted from the official record if the official voluntary withdrawal is before the middle of the term of instruction. If the official voluntary withdrawal is after the middle of the term of instruction, symbols are assigned by instructors to courses in which the student was enrolled as follows: W (no grade) to indicate passing or no basis for grade regardless of the grading system under which the student is enrolled, N to indicate failing in a course authorized for P-N grading, or 0.0 to indicate failing in a course authorized for numeric grading.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Rd
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under seperate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: The Warren Alpert Medical School of Brown University

Address Line 1:
Registration & Student Records

Address Line 2:
222 Richmond Street Box G-M1

City: Providence **State/Province:** RI **Zip Code (Postal Code):** 02912
Country: US

If name of institution was different when this individual attended, please note this name below:
Brown Medical School

Premedical Education:
Years of education required for admission to your medical school: 4 years - B.A. or B.S.
Credential/degree presented by the applicant for admission to your medical school: B.S.

Enrollment and Participation: Our records indicate that Johnston, Julie Ann
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 80 weeks of medical education on the following dates: From: 7,1,02 (Month Day Year) To: 5,31,04 (Month Day Year) *

This Individual
X Was awarded the degree of M.D. degree on 5,31,04 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

*PLEASE see attached letter.

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

SEAL VERIFIED

Name: Kathleen Chien
Signature: Kathleen Chien
Title: Director, Medical School Administration & REGISTRAR
Date of Signature: 10,11,13 Phone: (401) 863-5077
Fax: (401) 863-5096 Email: Kathleen_Chien@brown.edu

294365 294365 1546 1546 214568438

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? ___ YES ✓ NO

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the interruption/extension was approved or unapproved:

Personal/Family	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Academic remediation	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Health	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Financial	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in joint degree Program (e.g., MD/PhD)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-research special study (e.g., fellowship, international experience)	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Participation in non-degree research	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved
Other	From (Mo/Yr)___/___	To (Mo/Yr)___/___	___ Approved	___ Unapproved

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? ___ YES ✓ NO

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

Academic Probation	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for unprofessional conduct/behavioral	From (Mo/Yr)___/___	To (Mo/Yr)___/___
Probation for other reason	From (Mo/Yr)___/___	To (Mo/Yr)___/___

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? ___ YES ✓ NO

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

___ YES ✓ NO

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason?

If YES, please provide detailed documentation/information about the nature of the limitations or special requirements:

294365 294365 1546 214568438

BROWN
Alpert Medical School

Medical School Administration

October 11, 2013

Federation Credentials Verification Service
400 Fuller Wiser Road Suite 300
Euless, Texas 75039

To Whom It May Concern:

Subject: Julie Johnston, MD

This letter is to certify that Julie Johnston enrolled at The Warren Alpert Medical School of Brown University on July 1, 2002 and received her MD degree on May 31, 2004.

Dr. Johnston was admitted as a third-year advanced transfer student from Michigan State University College of Human Medicine in Lansing, Michigan.

If you require any additional information, you can contact me at 401-863-5077.

Sincerely,

Kathleen Chien
Director, Medical School Administration
& REGISTRAR

Brown University Box G-M1, Providence, RI 02912

294365

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Medical School

Medical Professional Name: Julie Ann Johnston

The Warren Alpert Medical School of Brown University

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Julie Ann Johnston

PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

BROWN
Alpert Medical School

OFFICE OF MEDICAL STUDENT AFFAIRS

Medical Student Performance Evaluation for

Julie Ann Johnston

November 1, 2003

Identifying Information

Julie Ann Johnston is a fourth-year medical student at Brown Medical School in Providence, Rhode Island. I am extraordinarily pleased to write this medical student performance evaluation in support of her application for a position in your house staff training program. Julie brings to her career in family medicine intelligence, maturity, outstanding communication skills, and a wide variety of community service and life experiences. She has encountered no significant challenges or hardships during medical school.

Julie grew up in Onsted, MI as the eldest of three children. Her father is a United Methodist minister and her mother is a special education teacher. She attended the University of Michigan in Ann Arbor, MI where she majored in microbiology and was a recipient of the Michigan Competitive Scholarship from 1995–1997. During college, she participated in numerous microbiology research projects. Julie was also very involved in a wide variety of extracurricular activities ranging from ballroom dancing to sailing to work for her interfaith campus ministry as a member of the Board of Directors and Finance Committee. She has a tremendous amount of broad life experience, having been an EMT, home health care aid, coop member, photographer, and nanny prior to entering medical school.

Academic History

Julie matriculated at Michigan State University College of Human Medicine in August, 2000 where she was a student until June, 2002 at which time she transferred to Brown Medical School. Her expected graduation date from Brown is May 31, 2004. She had no extensions or leaves of absence during medical school. She was not involved in any dual, joint or combined degree programs. She was not required to repeat or otherwise remediate any coursework during her medical education. She did not have any adverse action imposed on her by either medical school.

During her preclinical years at Michigan State, Julie was a very solid student. In Year 1, she received letters of commendation in two courses—microbiology and human development and behavior. In Year 2, she received recognition of Mastery Level Competency for Block 2. During her clinical years at Brown, she has received honors in several rotations. Throughout medical school, Julie has continued her well-established pattern of service and community involvement. She has been actively involved in several interest groups, medical societies,

Brown University Warren Alpert Medical School Box G-M2, 222 Richmond Street Providence, RI 02912
TEL: 401 863-1641 FAX: 401 863-3801

organizations that support reproductive choice, and the AMA. This year, she is also the American Academy of Family Practice Rhode Island student delegate.

Clerkship 1—Medicine: Julie began her clinical rotations with medicine and received a satisfactory grade. One resident wrote "Julie was truly superb as a medical student, routinely investigating clinical questions that came up on rounds and returning to educate the group, always going back to the books for learning. Julie also had a remarkably calm, professional demeanor with a real skill at doing procedures (better than most interns)." One of her faculty preceptors wrote "Julie was a pleasure to work with. She exhibited quiet confidence that benefited her colleagues and, no doubt, her patients. Her fund of knowledge was excellent. She was consistently interested in the teaching aspects of our patients, and her questions were always insightful." Another preceptor wrote "Julie was a pleasure to work with. She was a leader in our group and her presentations improved nicely over the course of five weeks. She will become a fine physician and will be dedicated to her work."

Elective 1—HIV/AIDS clinical care: She received honors. Her faculty preceptor wrote "Julie did an outstanding job. Her history taking and physical examination skills were wonderful. Her medical judgment was excellent. She was careful, thoughtful, and interacted in a wonderful manner with the staff, patients and families. She was very inquisitive and read independently."

Elective 2—Women's diagnostic imaging. She received honors. One attending physician noted "Julie was an active participant in the radiology department. She provided a three-page summary of a case and its findings as well, which was beyond the requirements of the rotation. Julie was always a pleasure to work with."

Clerkship 2—Psychiatry: She received a satisfactory grade. Her preceptor had the following comments: "Julie was consistently competent. Her confidence and overall performance on the rotation improved over time. She was an empathic listener, with a quiet but pleasant demeanor that patients appreciated."

Clerkship 3—Obstetrics & gynecology: She then received a satisfactory grade in her obstetrics & gynecology clerkship. A faculty preceptor thought "Julie was clearly interested in ob/gyn, and it showed. She was motivated to improve her knowledge base and went out of her way to do a good job. Julie did a great job on her presentations and on her written H&P's. She went above and beyond the 'call of duty' to teach herself how to use the slide maker software. She was refreshingly mature and was clearly interested in the subject matter." Her attending preceptor commented that "Julie was very personable and reliable. She interacted well with patients and staff." The nurse practitioners that she worked with observed "Excellent student. Excellent communication skills. Motivated -great to work with!" and "Very pleasant to work with. Comfortable clinically, responds well to feedback. Self-motivated student, quickly learned the routine of the clinic. Marked improvement clinically over two weeks."

Clerkship 4—Pediatrics: She received a satisfactory grade. Her senior resident commented "Julie gave two good didactic presentations with thorough handouts." A junior resident wrote "I was especially impressed with Julie's interest while following a patient with a new diagnosis of SLE. She took the initiative to talk with and educate the patient and her family and spent a good

deal of time with the patient. She also wrote very good H&P's with detailed differential diagnoses showing she thought critically about the presenting illnesses." Another senior resident wrote "Julie is a very avid learner, hardworking, and seems to be a team player."

Elective 3—Maternal & Child Health: She received honors. Her family medicine attending preceptor had the following comments: "She is a capable medical student, energetic and an interested, active learner. Julie was readily accepting of responsibility and conscientiously attended her patients. She was willing to take on additional work and often volunteered herself for more patient assignments. Her procedural skills steadily improved over the course of her month rotation. Her history taking is detailed and pertinent. Her physical exams were reliable and accurate. Julie worked well as a member of our team and was well liked by both nursing and physician staff. Julie performed at a level beyond expectation for her level of training and will make an excellent house officer and capable family physician."

Clerkship 5—Family Medicine: Her most recent rotation was in family medicine and she received honors. Her clinical preceptor commented, "Good with patients. Good knowledge base." She was noted to be skilled at patient education, able to fully integrate psychosocial issues into all aspects of patient care, to have an outstanding patient-doctor rapport, and to advocate for her patients. She worked well independently while also being a superb team player who regularly sought feedback.

Summary

In summary, Julie Johnston is a bright, well-spoken, thoughtful, and involved medical student with a tremendous amount of life and community service experience. Her successes both in and out of the classroom will serve her well in her career in family medicine. I recommend her highly and without any reservation for a position in your training program. Please do not hesitate to contact me if you need further information.

Sincerely yours,

Julie S. Taylor, MD, MSc
For the Postgraduate Referral Committee

294365

BROWN UNIVERSITY

Providence, Rhode Island 02912
OFFICIAL ACADEMIC TRANSCRIPT
401-863-2500

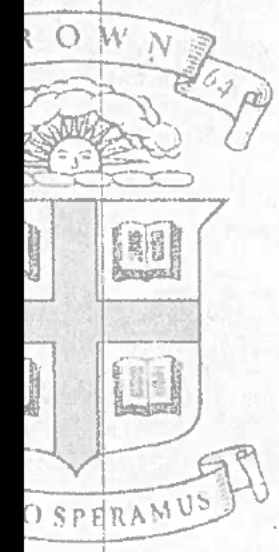
Name: Johnston, Julie Ann
Student Number: [redacted]

Record Date: 10/16/13

Code	Course Number	Course Title	Grade
[redacted]			

Code	Course Number	Course Title	Grade
[redacted]			

END OF TRANSCRIPT



SEAL
VERIFIED

Federation Credentials Verification Service

RAISED SEAL NOT REQUIRED

This official university transcript is printed on secured paper and does not require a raised seal. See reverse side to test for authenticity. The word VOID appears if photocopied. Background is in brown.

Robert F. Fitzgerald
University Registrar

294365 1546

Supplementary Information for Use in Evaluation of Transcripts

Official Transcript. An official transcript is a listing of courses for which a passing grade has been assigned. Courses from which a student withdraws or which are not completed satisfactorily are not entered.

Provision for other Material to be included with Transcripts. A student may elect to include other materials with the transcript as further information on academic work. The student provides this material and it is mailed with the transcript by the Registrar.

Grading System. The grading system described below became effective for undergraduates as of the beginning of the 1969-70 academic year and for graduate and medical students as of the beginning of the 1971-72 academic year. Since 1969, Brown University has not computed a Grade Point Average.

All courses are graded, subject to the conditions noted in the following paragraphs, on one of the three following bases: (1) A, B, C/No Credit (NC), or (2) Satisfactory (S) /No Credit (NC), (3) Honors (HNRS), Satisfactory (S) /No Credit (NC), Medical School courses only, effective academic year 1999-2000. Beginning Semester 1, 1974-75, an asterisk following a grade of S denotes that the choice of grade option for that course was not left to the student but was restricted to S/NC by the instructor. Although there is no minimum letter grade equivalent for Satisfactory (S), such an evaluation should be interpreted as comparable to the A, B, C/No Credit (NC) alternate system. As of fall 2009, Post-Baccalaureate Certificate Courses (indicated by Credit Type = C are graded only by option (1).

A minimum grade of either S or C in a 1000 or 2000 (100 or 200 prior to summer 2007) level course carries credit toward all advanced degrees; however, individual departments may, subject to approval of the Graduate Council, set higher grade requirements for specific advanced degree programs.

Pre-College Program. Courses (along with Advanced Placement credits) do not apply to the minimum quantity degree requirement. However, students with the appropriate amounts of these credits may use them for Advanced Standing.

Post-Baccalaureate Program. Courses in these programs do not apply to any advanced degree program without the expressed written consent of the Dean of the Graduate School, which would be noted in the remarks section of the record.

Academic Calendar. The normal academic year consists of two semesters of approximately fifteen weeks each.

Full-time and Part-time Enrollment. The normal full-time undergraduate course load is four courses per semester for eight semesters; however, a full-time student may elect to take three, four, or five courses in an given semester. Where course enrollment is not pertinent to the determination of full-time enrollment status (e.g., graduate students working on a thesis), such status is determined by the Dean. Permission of the Dean is required for part-time enrollment.

Unit of Credit. The unit of credit is the semester course. This is defined as one-fourth of a normal program of academic work for one semester (four courses) and, for purposes of evaluation, may be considered the equivalent of four semester hours of credit.

Course Numbering System. In the summer of 2007, the course numbering ranges were expanded from 100's to 1000's. This change was not made retroactively to courses that pre-date summer 2007. Courses numbered 1 to 999 (1-99 prior to summer 2007) are open to undergraduates. On occasion, however, and with approval of the student's department and the Dean, a graduate student may register for such a course with extra work for graduate credit, and this will be so noted. This provision does not apply to course level 1-999 (1-99 prior to summer 2007) taken for graduate credit by students in the Master of Medical Science program. Courses numbered 1000-1999 (100-199 prior to summer 2007) are open to undergraduates and graduate students. Courses numbered 2000-2999 (200-299 prior to summer 2007) are open to graduate students, and by special arrangement, to undergraduates. Courses numbered 3000 and above (300 and above prior to summer 2007) are open only to students in the School of Medicine.

Audits. Academic course credit is not granted for courses which are audited; however, an Audit is included on the permanent record only if the instructor concurs that the course work completed is acceptable as an Audit.

Degrees with Distinction. Baccalaureate degrees are awarded with one level of distinction only, magna cum laude, to approximately 20% of the graduating class.

Index to Grades and Codes

Grades Reported

A,B, or C
S = (Satisfactory)
S* = (Satisfactory) - restricted by instructor
HNRS = Honors (Medical only)
INC = Incomplete
ABS = Absent from final examination
M = Missing. Grade not submitted at time report was prepared
AUDIT = See paragraph above
ED = Existing deficiency (Medical only)
T = Transfer Credit

Academic Status Codes

AW = Warning
SW = Serious Warning

Grade Codes

* = Restricted to S/NC Option

Enrollment Codes

P = Part Time

Special Course Codes

EXCH = Courses taken on Brown Exchange Program
SAB = Courses taken on Alternative Brown Study Abroad Program

Course Type Codes

Y = Year course
R = R.I. School of Design

Credit Values

C = Post-Baccalaureate Certificate
V = Quarter Credit
H = Half Credit
D = Double Credit
T = Triple Credit
Q = Quadruple Credit
U = Quintuple Credit
N = Non-Credit
E = Extra Credit Required for Graduate Credit
X = Equivalent 6 Sem. Hrs. Practice Teaching
Z = Equivalent 12 Sem. Hrs. Practice Teaching
W = Weeks of Medical Clerkship
% = Pre-College Program - see above

Office of the Registrar
Brown University
(401) 863-2500

UNIVERSITAS BRUNENSIS

PROVIDENTIAE

IN RHODIENSIS INSULAE REPUBLICA
OMNIBUS HAS LITTERAS LECTURIS SALUTEM IN DOMINO SEMPITERNAM

VOBIS NOTUM SIT QUOD PRAESES UNIVERSITATIS CUM AUCTORITATE
A SOCIIS HONORANDIS EI COMMISSA PUBLICIS IN COMITIIS DECORAVIT

JULIE ANN JOHNSTON

GRADU

DOCTORIS MEDICINAE

CANDIDATUM COMPETENTEM ET EXAMINE USITATO PROBATUM NON SOLUM PERITUM AD SANANDI ARTES SED ETIAM IN MEDICINAE SCIENTIA DOCTUM ET HUIC OMNIA PRIVILEGIA IURA HONORES INSIGNIA IIS AD HUNC GRADUM EVECTIS PERTINENTIA FRUENDA DEDIT

CUIUS IN REI TESTIMONIUM NOS HIS LITTERIS UNIVERSITATIS SIGILLO MUNITIS NOMINA NOSTRA SUBSCRIPSIMUS

DATUM IN SOLEMNIBUS ACADEMICIS PROVIDENTIAE HABITIS DIE TRICESIMO PRIMO MAII ANNOQUE DOMINI NOSTRI MMIV

SECRETARIUS

PRAESES

SEAL
VERIFIED

CERTIFIED AS a true copy of the original medical school diploma awarded to Julie Ann Johnston, MD from Brown University on 5/31/04.

Kathleen Chien
Director, Medical School Administration
& REGISTRAR

10-11-13
DATE

9hsl

5926b7

BROWN
Alpert Medical School

Medical School Administration

BROWN UNIVERSITY
AT PROVIDENCE
IN THE STATE OF RHODE ISLAND

To all men who are about to read this document everlasting greetings in the Lord

Be it known to you that the President of the University with the authority entrusted to him by the Board of Fellows has bestowed in public assembly

JULIE ANN JOHNSTON

with the degree of

DOCTOR OF MEDICINE

as a candidate fully qualified and approved through the process of examination not only experienced in the arts of healing but also learned in the science of medicine and to him has given to enjoy all the privileges and honors and rights and symbols pertaining to those advanced to this degree.

In testimony whereof we have added our names to this document sealed with the great seal of the University.

Granted in academic ceremonies held in Providence on the 31st day of May in the year of our Lord 2004.

/s/ Wendy J. Strothman
Secretary

/s/ Ruth J. Simmons
President

***Certified as a true copy of the English translation of the Medical School diploma received by Julie Ann Johnston, M.D. from Brown University on May 31, 2004.**

Kathleen Chien
Director, Medical School Administration

10-11-13
Date

SEAL
VERIFIED

294365

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

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: Greater Lawrence Family Health Center

Attention: Program Director

Specialty: Family Medicine

Affiliated University: UMASS

Address: Lawrence, MA

Verification For:

Name: Johnston, Julie Ann

DOB: [redacted]

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

Specialty/Subspecialty: Fam Med

From: 06/15/2004 To: 06/16/2005

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

Specialty/Subspecialty: Fam Med

From: 06/17/2005 To: 06/18/2006

Successfully Completed?: ☒ Yes ☐ No ☐ In Progress

Accredited by: ☒ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

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

Specialty/Subspecialty: Fam Med

From: 06/19/2006 To: 06/22/2007

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 signature verified

ELECTRONIC SEAL VERIFIED

Name: Joseph Gravel, MD

Signature: Joseph Gravel, MD

Title of Signatory: Program Director

Date of Signature: 12/12/2013

Tel: _____ Fax: _____ E-Mail: _____

Rev. 12/11/2013

FCVS ID: 294365 FID: 214568438 CODE: 104229

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Applicant Reported Unusual Circumstances

Federation of STATE MEDICAL BOARDS

Graduate Medical Education

Medical Professional Name: Julie Ann Johnston
Greater Lawrence Family Health Center
Family Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Julie Ann Johnston

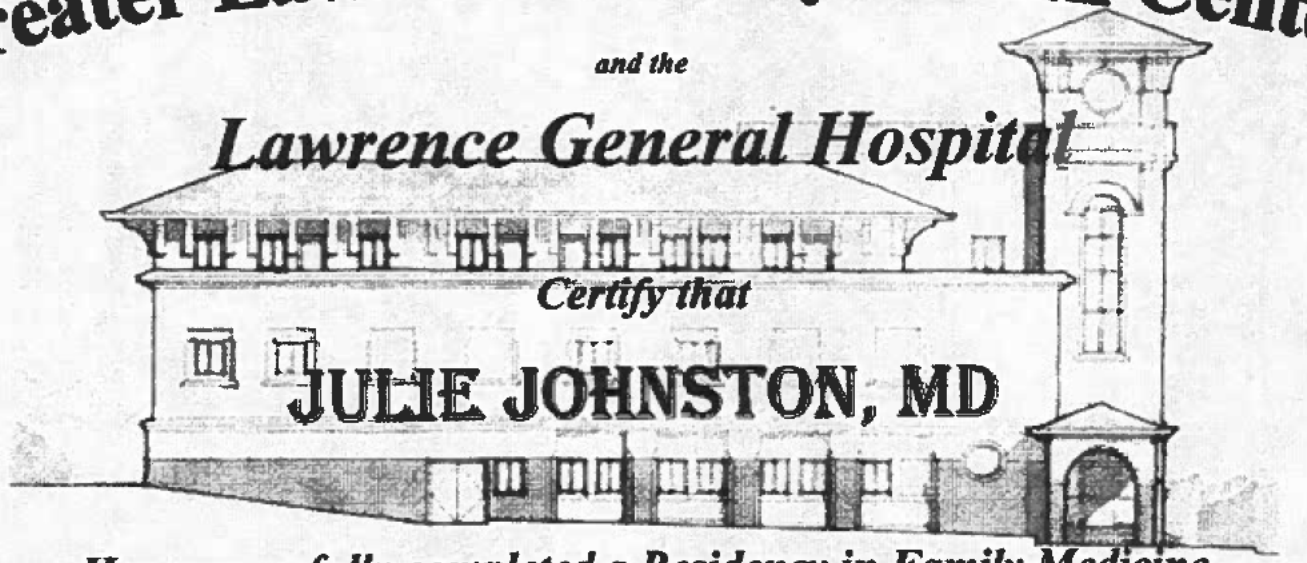
PROVIDED BY APPLICANT

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Greater Lawrence Family Health Center

and the

Lawrence General Hospital



Certify that

JULIE JOHNSTON, MD

Has successfully completed a Residency in Family Medicine
From July 2004 through June 2007
Given on the twenty second day of June in the year of two thousand and seven

Greater Lawrence Family Health Center
Chief Executive Officer

Greater Lawrence Family Health Center
Medical Director

Lawrence General Hospital
President & Chief Executive Officer

Lawrence Family Practice Residency
Program Director

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

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 : 09/26/2013

Recipient:

Federation Credentials Verification Service
ATTN: FCVS

Packet ID: 294365

Examinee: Johnston, Julie Ann
Alt Name(s): Johnston, Julie A

Examinee ID#: [redacted]
Date of Birth: [redacted]

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	[redacted]	Comments
	06/18/2002	Pass		

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail	[redacted]	Comments
	09/25/2003	Pass		

USMLE STEP 3

	Test Date	Pass/Fail	[redacted]	Comments
MASSACHUSETTS	08/03/2006	Pass		

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

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

Examinee: Johnston, Julie Ann

Examinee ID#: [redacted]
Date of Birth:

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances <u>not</u> in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note.

4/2013

FP(BC)

10/3/13

Uniform Application for Physician Licensure

UA Username juliejohnstonmd
FCVS Status Applicant has an FCVS Packet

Date Submitted 10/2/2013

1. Name: Indicate your full legal name. If your name has changed at any time during your life and you are not using FCVS, you must submit a copy of the legal document (marriage certificate, divorce decree, etc.) supporting your name change.

1. Full Name (use no initials)

Last Name	Johnston
First Name	Julie
Middle Name	Ann
Suffix	
Maiden Name	
M.D.	[X]
D.O.	[ ]

All other names used

First	Middle	Last	Suffix
Julie	A	Johnston	

2. Address/Phone: Please complete all sections and indicate which address you wish to be used for public access and which is to be used for mailings from the medical board. Each state's law determines whether each address or phone number is a public record in the state in which you are applying. You may wish to contact the licensing authority for that state for further information. Many boards publish the "Public Access" address on their website, therefore you should consider what your preferred address is for these purposes.

2. Address/Phone

Business

[ ] Public Access
[X] Mailing

Street [redacted]
City [redacted] State/Province [redacted] Zip Code [redacted]
Country
Telephone
Fax
Email
Alternate Phone

Home

[X] Public Access
[ ] Mailing

Street [redacted]
City [redacted] State/Province [redacted] Zip Code [redacted]
Country
Telephone
Fax
Email
Alternate Phone

JOHNSTON, JULIE ANN

3. Identification: If you are not using FCVS, you must submit either a notarized copy of your birth certificate or a notarized copy of your current, valid passport.

3. Identification

[redacted]

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

F (Gender) | [redacted] (Social Security Number) | [redacted] (NPI) | Are you a U.S. Citizen? [X] Yes [ ] No

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. Section 666 and applicable state law). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. Section 11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with state laws governing physician discipline or as otherwise required by state or federal law.

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. For more information on the NPI, please go to http://www.cms.hhs.gov/NationalProvidentStand/.

4. Medical School: List all medical schools you have attended, even those from which you did not graduate, in chronological order. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Medical Education Verification" form and send it to all medical schools you have attended. You must include a copy of your diploma to which the medical school must attach their seal prior to forwarding it to this Board. Additionally, the medical school must provide this Board with an official copy of your transcripts. The medical school must forward all documentation directly to this Board.

4. Medical School

1
School Name Michigan State University College of Human Medicine
Address A-110 East Fee Hall
City East Lansing
State/Province MI
ZIP Code 48824
Country USA
Attendance Dates **From (mm/yyyy)** 09/2000 **To (mm/yyyy)** 06/2002
Graduation Date
Degree

2
School Name The Warren Alpert Medical School of Brown University
Address Office of Student Affairs
97 Waterman Street Box G A2
City Providence
State/Province RI
ZIP Code 02912
Country USA
Attendance Dates **From (mm/yyyy)** 07/2002 **To (mm/yyyy)** 05/2004
Graduation Date 5/31/2004
Degree MD

5. Fifth Pathway: If you attended a Fifth Pathway program and are not using FCVS, you must complete the attached "Fifth Pathway Verification" form and send it to your medical school and to the institution where you completed your rotations. You must include a copy of your diploma. The medical school and institution must forward all documentation directly to this Board.

5. Fifth Pathway (if applicable)

Medical School Name			
Address			
City			
State/Province			
ZIP Code			
Country			
Attendance Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Graduation Date			
Degree			

Institution name where rotations performed

Address			
City			
State/Province			
ZIP Code			
Country			
Rotation Dates	**From (mm/yyyy)**	**To (mm/yyyy)**	**In Progress**
Certification Date			

6. Postgraduate Training: List **all** postgraduate programs you have attended, even those you did not complete. Attach an additional sheet if necessary. If you are not using FCVS, you must complete the attached "Postgraduate Training Verification" form and send it to **all** postgraduate training programs you have attended. You must submit a copy of your certificate of program completion to this Board. The postgraduate program must forward all documentation directly to this Board.

6. Postgraduate Training

1

Hospital Name Greater Lawrence Family Health Center
Hospital Address 34 Haverhill Street

City Lawrence
State/Province Massachusetts
ZIP Code 01841-2884
Country USA

PGY: (e.g., 1, 2, 3, etc.) [X] **Internship** [X] **Residency** [ ] **Fellowship** [ ] **Research** [ ] **Other**

Department/Specialty Family Medicine

From: 06 /2004 **To:** 06 /2007 **Successfully Completed?** [X] **Yes** [ ] **No** **In Progress** [ ]

Month Year Month Year

7. Examination History: If you are not using FCVS, you are responsible for contacting the appropriate examination entity and having a certified transcript of your scores sent directly to this Board.

7. Examination History

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below

Examination	State	Most Recent Date taken(Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step 1		06/2002	[X] P	[ ] F	1
USMLE Step 2		09/2003	[X] P	[ ] F	1
USMLE Step 3		08/2006	[X] P	[ ] F	1

8. ECFMG: If ECFMG is applicable and you are not using FCVS, you are responsible for contacting ECFMG and having a certified "Status Report" forwarded directly to this Board. There is a separate fee for this report. Reports can be obtained through the ECFMG web site at www.ecfmg.org.

8. ECFMG (if applicable)		
Certificate Number	**Issue Date**	Valid Through Date

9. State or Professional Licensure: List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must also complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any health care license or certification. The verifying entity must forward all documentation directly to this Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements.

9. State Licensure

1	**State/Province**	MA	**Practitioner Type** (MD, DO, etc.)	MD	**Type of License** (Full, Temporary, etc.)		
	License Number	231502	**Status**	Active	**Issue Date**	8/1/2012	

10. Chronology of Activities: List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address.* If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical administrative duties.

10. Chronology of Activities

Dates: From/To	Practice/Employment
1 From: Month: 06 Year: 2004 To: Month: 06 Year: 2007 In Progress ☐	**Practice/Employment Name** Lawrence Family Medicine Residency (or list non-working time as indicated above) **Practice/Employment Address** 34 Haverhill Street **City** Lawrence **State/Province** Massachusetts **ZIP Code** 01841 **Country** USA **Position and Department** Resident-Residency **Percent Clinical:** 100% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
2 From: Month: 07 Year: 2007 To: Month: 09 Year: 2007 In Progress ☐	**Practice/Employment Name** Vacation (or list non-working time as indicated above) **Practice/Employment Address** [redacted] **City** [redacted] **State/Province** [redacted] **ZIP Code** [redacted] **Country** USA **Position and Department** **Percent Clinical:** 0% **Percent Administrative:** 0% **Employment** ☐ **Staff Privileges** ☐ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
3 From: Month: 09 Year: 2007 To: Month: Year: In Progress ☒	**Practice/Employment Name** Greater Lawrence Family Health Center (or list non-working time as indicated above) **Practice/Employment Address** 34 Haverhill Street **City** Lawrence **State/Province** Massachusetts **ZIP Code** 01841 **Country** USA **Position and Department** Family Physician-Family Medicine **Percent Clinical:** 67% **Percent Administrative:** 33% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

Dates: From/To	Practice/Employment
4 From: Month: 05 Year: 2013 To: Month: Year: In Progress ☒	**Practice/Employment Name** Health Quarters Inc. (or list non-working time as indicated above) **Practice/Employment Address** 100 Cummings Center Suite 126-R **City** Beverly **State/Province** Massachusetts **ZIP Code** 01915 **Country** USA **Position and Department** Medical Director-Clinical Care **Percent Clinical:** 10% **Percent Administrative:** 90% **Employment** ☒ **Staff Privileges** ☒ **Affiliation** ☐ **Other**

11. Malpractice: List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please have your information available before reviewing this section and contact the state board or FCVS to make changes.

11. Malpractice Liability Claims Information

Name of patient involved:

In which state did the action take place? **Case number (if applicable)**

Which court?
(If private compromise or settled before initiation of civil action, state here)

Current status of claim:

☐ Open (pending) ☐ Closed (settled or judgment) ☐ Dismissed (no money paid out) ☐ Other

Amount of judgement or settlement $ **Amount paid on your behalf $**

Month and year of event precipitating claim:

Month and year of lawsuit:

Insurance carrier at time:

What is/or was your status? ☐ **Primary defendant** ☐ **Co-defendant** ☐ **Other**

Please provide specifics in reference to the adverse event including the allegations and your role in the event:

UA UNIFORM APPLICATION FOR PHYSICIAN STATE LICENSURE

Affidavit and Authorization for Release of Information

Applicant: Send this form to the state board you are applying to. Do not send this to FSMB.

Applicant:

Securely tape or glue a recent (less than 6 month old) front-view 2" x 2" passport-type color photo of yourself in the square below.

Sign this form with attached photo in the presence of a notary public.

Send the notarized form to the board you are applying to for licensure.

DO NOT SEND THIS FORM TO FSMB.

Doing so will cause a delay with your state board application.

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor of and person named in the various forms and credentials furnished or to be furnished with respect to my application, and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Uniform Application for Physician State Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data, and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge, and exonerate the Board, its agents or representatives, and any person, hospital, clinic, government agency (local, state, federal, or foreign), court, association, institution, or law enforcement agency having custody or control of any documents, records, and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the Board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the Board.

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my license or permit to practice medicine.

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

Johnston

Applicant's printed last name

Julie, A

Applicant's printed first name, middle initial, and suffix (e.g., Jr.)

10/2/13

Date of signature (must correspond to date of notarization)

Notary

State of Massachusetts, County of Essex

I certify that on the date set forth below, the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document.

The statements on this document are subscribed and sworn to before me by the applicant on this 2nd day of October.

Notary Public Signature: Tarialy Hernandez

My Notary Commission Expires: 12/26/14

TARIALY HERNANDEZ
Notary Public
COMMONWEALTH OF MASSACHUSETTS
(NOTARY PUBLIC SEAL)
My Commission Expires
December 26, 2014

RECEIVED
OCT - 4 2013
NH BOARD

ADDENDUM TO APPLICATION

Applicant Name Julie Johnston, MD **Date** 10/2/13

Please answer the following questions. **If you answer "yes" to any of these questions, please explain on the reverse side of this sheet, or an attach an additional 8 ½" x 11" sheet(s) if necessary.**

1. Have you been actively engaged in the practice of clinical medicine within the past 12 months? Yes ☑ No ☐
2. Are you certified by an American Specialty Board? (If yes, provide a notarized copy of all certificates.) Yes ☑ No ☐
3. Have you ever, for any reason, lost American Specialty Board Certification? Yes ☐ No ☑
4. Have you been denied required recertification by any specialty boards? (If yes, list each board and dates denied.) Yes ☐ No ☑
5. Has any medical malpractice suit been brought against you or has any claim been settled on your behalf in the last ten years? (If so, list each suit/claim on the Malpractice Liability Claims Information page within the online Uniform Application.) Yes ☐ No ☑
6. Have you ever applied for licensure or to sit for an examination, or taken an examination, under a different name? Yes ☐ No ☑
7. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating or improper conduct during an examination since you graduated from high school? Yes ☐ No ☑
8. Have you ever failed any national medical licensure examination or any part of that examination, state board examination, or failed to gain certification from the National Board of Medical Examiners? **You must report all exam failures, even if you later passed the examination.** (This does not include specialty board certification examinations.) Yes ☐ No ☑
9. Have you ever failed a foreign licensing or certification examination? Yes ☐ No ☑
10. Have you ever been denied a medical license, whether full, limited, or temporary, for any reason? Yes ☐ No ☑
11. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, limited, suspended, or revoked, or have you ever resigned from a medical staff in lieu of disciplinary action? Yes ☐ No ☑
12. Is any investigation or disciplinary action pending, or has any investigation or disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)? Yes ☐ No ☑
13. Have you ever voluntarily surrendered a license to practice medicine or any healing art or allowed such a license to lapse in lieu of facing disciplinary investigation or action? Yes ☐ No ☑
14. Have you ever withdrawn an application for licensure, hospital privileges, or appointment for any reason? Yes ☐ No ☑

Applicant Name Julie Johnston, MD **Date** 10/2/13

15. Have you ever been a defendant in a criminal proceeding including driving while under the influence or driving while suspended, which has not been annulled by a court, but not including traffic offenses not classified as misdemeanors or felonies? Yes ☐ No ☑

16. Has your privilege to possess, dispense, or prescribe controlled substances ever been suspended, revoked, denied, restricted, or surrendered, or have you ever been charged, investigated, or warned by a state or federal agency based on controlled substance issues? Yes ☐ No ☑

17. Have you ever had any physical, emotional, or mental illness which has impaired or would be likely to impair your ability to practice medicine? Yes ☐ No ☑

18. Are you now, or have you, during the past 5 years, been dependent upon alcohol or habituating drugs, or undergone treatment for such? Yes ☐ No ☑

Anticipated Practice Location(s) (if known):

Joan G. Lavering Health Center, Greenland, NH

Applicant's Signature	Applicant's Printed Last Name	Date of Signature
[signature]	Johnston	10/2/13

1. Please see CV, yes I have been practicing medicine in MA.

For Board Use Only:

Application Received: Oct. 4, 2013 Fee Paid: $300 Check # 2416

License Number: _____ Date of Issue: _____

Julie Ann Johnston, M.D.
[redacted]
Cell: [redacted]
Email: [redacted]

Experience

Attending Family Physician, 9/07-present
Greater Lawrence Family Health Center, Lawrence, MA
Lawrence General Hospital, Lawrence, MA

- Provide primary care in the clinic and hospital setting
- Attend patients at Lawrence General Hospital on Obstetric and Pediatric services
- Teach and supervise residents
- Centering Pregnancy Facilitator, patient centered group prenatal care

Gynecology/Women's Health Rotation Coordinator, 3/08-present
Lawrence Family Medicine Residency, Lawrence, MA

- Give lectures to residents, organize curriculum
- Coordinate women's health procedural training for other providers
- Train family medicine obstetric fellows in miscarriage management
- Run the Reproductive Health Interest Group for residents

Medical Director, 5/13-present
Health Quarters Inc., Beverly, MA, Haverhill, MA, Lawrence MA,

- Supervise clinicians
- Oversee the CLIA laboratory
- Develop reproductive health clinical protocols
- Provide quality improvement activities

Clinical Instructor, 5/09-present
Tufts University School of Medicine, Boston, MA

- Teach medical students weekly in the office setting
- Preceptor for the Competency based Curriculum in Primary care (CAP)

Education

Faculty Development, 11/10-6/11
University of Massachusetts Medical School, Worchester, MA

- Teaching for Tomorrow

Residency- Family Medicine, 6/04-6/07
Lawrence Family Medicine Residency, Lawrence, MA

- Completed BLS, ACLS, NRP, PALs, FCC, ATLS, and ALSO courses

M.D.
Brown University, 5/04 — Providence, RI
Michigan State College of Human Medicine, 8/00-5/02 — East Lansing, MI

B.S.
University of Michigan, Microbiology, 5/99 Ann Arbor, MI

Licensure/Board Certification

Diplomat: American Board of Family Medicine, 2007
Massachusetts Medical License, active
Advanced Life Support in Obstetrics (ALSO) Instructor, 2009

Leadership

MA Postpartum Depression Legislative Commission Appointee, 2011-present
MA Academy of Family Physicians Legislative and Regulatory Affairs committee member 2005-present
MA DPH Peri-natal Advisory Committee member, 2008-present
MA DPH Postpartum Depression Working group, 2010-2011

Awards

Residency Innovation Award, 6/2010
Lawrence Family Medicine Residency

Languages

Spanish

Professional Affiliations

American Association of Family Physicians, 2002-present
Association of Reproductive Health Professionals, 2008-present
Society of Teachers of Family Medicine, 2010-present

Greater Lawrence Family Health Center

34 Haverhill Street • Lawrence, MA 01841-2884
(978) 725-7400 • TTY (978) 689-6438 • Fax (978) 687-2106
www.GLFHC.org

October 28, 2013

GLFHC
Office of the Medical Director
34 Haverhill Street
Lawrence, MA 01810

To Whom It May Concern,

We are responding to a request for reference for Julie Johnston, MD. She has been employed at GLFHC since July 2004.

Documentation:	exemplary	satisfactory	unsatisfactory
Clinical skills:	exemplary	satisfactory	unsatisfactory
Communication:	exemplary	satisfactory	unsatisfactory
Clinical skills/quality:	exemplary	satisfactory	unsatisfactory

We are happy to recommend Julie Johnston, MD with no reservations.

Sincerely,

Zandra Kelley, MD
Greater Lawrence Family Health Center, Medical Director
Lawrence General Hospital, Chief of Family Medicine
34 Haverhill Street
Lawrence, MA 01841

Lawrence General Hospital
So good. So caring. So close.

1 General Street
PO Box 189
Lawrence, MA 01842-0389
(978) 683-4000

October 28, 2013

To Whom It May Concern:

The following is in response to your request for information and is provided to you in lieu of completion of the evaluation form you submitted. This information is based upon review of the practitioner's file and should provide the necessary documentation.

APPLICANT'S NAME:	**Julie Johnston, MD**	**CATEGORY:**	Associate
APPOINTMENT PERIOD:	8/29/2012–8/28/2014	**SUBSPECIALTY:**	Family Medicine w/OB
INITIAL APPOINTMENT:	7/20/2007	**DEPARTMENT:**	Family Practice
DATE LEFT IF APPLICABLE:			

I have been authorized by vote of the Medical Executive Committee to provide the following information.

The above named individual has been fully credentialed at Lawrence General Hospital in accordance with Massachusetts Law 243 MCR 3.05, JCAHO, and NCQA Regulations.

Clinical Skills: This practitioner continues to meet the clinical performance and health requirements to qualify for reappointment at Lawrence General Hospital.

To the best of our knowledge the applicant has/has not been subject to pending or final:

A. Disciplinary action as defined in 243 CMR 3.02?	*[ ]	Yes	[X]	No
B. Disciplinary action by a state licensing board?	*[ ]	Yes	[X]	No
C. Monitoring or treatment program for drug or alcohol misuse?	*[ ]	Yes	[X]	No

*Please refer to attached documentation.

Liability Claims: Refer to application for re-licensure-Massachusetts Board of Registration in Medicine or to malpractice claims loss history.

Admitting Privileges Granted to all active categories (Associate, Senior, and Honorary Active) with the exception of affiliate, consulting and the hospital based departments (Anesthesiology, Emergency Medicine, Pathology and Radiology).

If you require further information, please do not hesitate to contact the Medical Staff Office at (978) 946-8185. Thank you.

Ann-Marie Giamusso, CPCS
Director, Medical Staff Services

Greater Lawrence Family Health Center

34 Haverhill Street • Lawrence, MA 01841-2884
(978) 725-7400 • TTY (978) 689-6438 • Fax (978) 687-2106
www.GLFHC.org

New Hampshire Board of Medicine
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

September 30, 2013

Dear Sir/Madam,

I am writing on behalf of Dr. Julie Johnston with reference to her application for medical licensure in the state of New Hampshire.

I have known Dr. Johnston since 2004 when she entered the Lawrence Family medicine residency program, where I am a faculty member in charge of coordinating the Obstetrics curriculum. I have had the opportunity to teach and supervise Dr Johnston both at the Greater Lawrence Family Health Center where the residency is based and at Lawrence General Hospital where I have privileges and where our residents do their inpatient rotations.

She has always been interested in women's health and was quite resourceful in carving out learning opportunities for herself during residency, gaining expertise in miscarriage management, contraceptive management and natural childbirth.

She joined the staff of the Greater Lawrence Family Health Center in 2007 and since then has also had privileges at the Lawrence General Hospital, where she cares for patients on the pediatric and obstetric services. She has continued to play a leading role in women's health. In her capacity as curriculum coordinator for gynecology in the Lawrence Family Residency program, she trains residents and faculty in gynecology related outpatient procedures , educates through lectures and workshops. She also facilitates prenatal groups and is an Instructor in Advanced Life Support in Obstetrics. Her passion for teaching led her to improve her already commendable teaching skills, by participating in the UMASS sponsored Teaching of Tomorrow program for primary care faculty. Dr. Johnston also teaches medical students.

Dr. Johnston is well liked and respected by colleagues, is quite conscientious in her work, provides compassionate patient care and holds herself and others to high ethical standards. She is also quite innovative, recently engineering a way for patients to get contraceptive intradermal implants following delivery, prior to hospital discharge. She is also in the process of introducing immediate post delivery intrauterine contraceptive device placement.

Besides her work for the health center and residency, she has taken a leadership role in state wide committees and organizations such as the Massachusetts Academy of Family Physicians and the Perinatal Advisory committee. In all this she is successfully balancing family life, mothering two young children, while enjoying cooking and gardening.

I have no hesitation in highly recommending Dr Johnston for medical licensure in New Hampshire.

Sincerely,

E. Edgings Pryce MD

Eloise Edgings-Pryce, M.D.
Coordinator Obstetrics Curriculum
Lawrence Family Medicine Residency

R

Greater Lawrence Family Health Center
@ Lawrence General Hospital
One General Street - Lamprey Building, 4th Floor, Lawrence, MA 01842-0389
Phone: (978) 983-0488

September 24, 2013

New Hampshire Board of Medicine
2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520

RE: Julie Johnston, MD

To Whom It May Concern,

This letter is in reference to the New Hampshire licensing of Julie Johnston. I have known Julie since she was a resident at Lawrence Family Medicine Residency. Since graduation, she has joined our faculty and is now the GYN curriculum coordinator. As the OB Fellowship Director, she and I have occasion to work closely together. I have nothing but positive things to say about her. She is a person of exceptional moral character and is an excellent physician. She is strong willed and fights for patients' rights.

Clinically, I work mostly with Dr. Johnston in the area of women's health and on labor and delivery. Her medical knowledge in these areas is extraordinary. She is also an excellent teacher and values the importance of caring for the underserved patient population.

Sincerely,

Robyn Stewart, DO
Greater Lawrence Family Health Center
Lawrence Family Medicine Residency
1 General St, Lamprey Bldg 4th Fl
Lawrence, MA 01841
978-382-8098

LAWRENCE FAMILY MEDICINE
RESIDENCY

34 Haverhill Street • Lawrence, Massachusetts 01841
(978) 725-7410 • Fax (978) 687-2106 • Email: residency@glfhc.org • www.lawrencefmr.org

Sponsored by the Greater Lawrence Family Health Center, Inc.

Re: Dr. Julie Johnston

To Whom It May Concern:

As her advisor in residency and subsequently as a colleague, I have worked with Dr. Julie Johnston over the past 9 years. She is a highly skilled and professional physician who has contributed extraordinarily to our organization and to women's health in our community. She has been on faculty at our family medicine residency training program since completion of residency, and has recently been promoted to our core faculty group in recognition of her overall excellence.

Overall, Dr. Johnston's professional stature and high moral character make her an asset to any organization where she chooses to work. I would recommend her without reservations.

Sincerely,

Cara Marshall MD

Cara Marshall, MD
Core Faculty, Lawrence Family Medicine Residency

DEVAL L. PATRICK
GOVERNOR

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

10/17/2013

To Whom It May Concern:

This certifies that Julie A Johnston, M.D., a 2004 graduate of Brown University School of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 231502 was issued to Dr. Johnston on 06/06/2007. The license status is: Active. The expiration date is 8/28/2014.

Listed below is certain complaint and disciplinary information on this physician. Please note that the Board can neither confirm nor deny the existence of open complaints.

Closed Complaint Information

Our files contain 0 closed complaint(s) on this physician.

Final Board Disciplinary Action

Our files contain 0 disciplinary action(s) taken against this physician by the Board.

This information is derived from Board files from January 1, 1987 to the present. It does not include all the information contained in a license application.

As a service to the public and to designated agencies, the Massachusetts Board of Registration in Medicine offers an online profile of all physicians with full licenses who are licensed in the Commonwealth. This profile is updated daily and may include public information that is not otherwise contained in this certification letter. You may access this information at the Board's website:

www.mass.gov/massmedboard

Finally, the Board tallies closed complaints separately from disciplinary actions. If the same underlying incident gives rise to both a complaint and a disciplinary action, the Board counts this as two separate actions. In the same way, multiple disciplinary actions are tallied separately, even if they arise from a single set of circumstances.

Francee L Mulero

SEAL

Staff Member, Board of Registration in Medicine

Francee Mulero

American Board of Family Medicine

Julie A. Johnston, M.D.

having met all its requirements
is hereby certified to be a

Diplomate

of this Board for the period

2007-2014

The Commonwealth of Massachusetts
On this 26th day of Sept., 2013
I certify that the diploma
document is a true, exact, complete and unaltered copy
of the original.
MICHELLE OLIVIERI, Notary Public
My Commission Expires November 25, 2016

The Commonwealth of Massachusetts
On this 26th day of Sept, 2013
I certify that the DEA Cert.
document is a true, exact, complete, and unaltered copy
of the original.
MICHELLE OLIVIERI, Notary Public
My Commission Expires November 25, 2016

JOHNSTON, JULIE, A
JULIE JOHNSTON
[redacted]

RECEIVED
OCT 4 2013
NH BOARD

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
[redacted]	12-31-2015	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	11-28-2012

JOHNSTON, JULIE, A
GREATER LAWRENCE FAMILY HEALTH CENTER
700 ESSEX ST.
LAWRENCE, MA 01841-0000

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

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

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

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

DEA REGISTRATION NUMBER	THIS REGISTRATION EXPIRES	FEE PAID
FJ0321492	12-31-2015	$731

SCHEDULES	BUSINESS ACTIVITY	ISSUE DATE
2,2N, 3,3N,4,5,	PRACTITIONER	11-28-2012

JOHNSTON, JULIE, A
GREATER LAWRENCE FAMILY HEALTH CENTER
700 ESSEX ST.
LAWRENCE, MA 01841-0000

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

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

Form DEA-223 (4/07)

The Commonwealth of Massachusetts

On this _____ day of _____, 20___

I certify that the _____

document is a true, exact, complete and unaltered copy

of the original.

MICHELLE OLIVIERI, Notary Public

My Commission Expires November 25, 2016

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

JOHNSTON, JULIE MD 10/4/13

This will acknowledge receipt of your application for licensure to practice medicine in the State of New Hampshire.

Upon review of the application, it has been found that the following items must be completed:

Certification of:

X FCVS	_____PERSONAL AFFIDAVIT
_____CURRICULUM VITAE	_____PHOTOGRAPH
_____FEE OF $300.00	_____SIGNATURE
_____STATE CLEARANCE (_____)	_____EXPLANATION OF QUESTION #_____

_____DEA CERTIFICATE (NOTARIZED) If you don't have a DEA certificate please put it in writing to the Board of Medicine.

_____AMERICAN SPECIALTY BOARD CERTIFICATES (NOTARIZED)

X NH & FBI CRIMINAL HISTORY RECORD CHECKS

X rec'd 3 (need 1 more) REFERENCE LETTERS - (Total of 4). 2 of these must be original letters from hospital administrator and chief of staff where current privileges are held (If you are in a training program, have letters sent from program director and another staff individual who knows your abilities). Remainder must be from physicians who can attest to your moral character and professional abilities.

COMMENTS: Letters rec'd are from Drs' Edgings - Price, Stewart, & Marshall.

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

DCN: 5500000085518642
Process Date: 11/01/2013
Page: 1 of 1
JOHNSTON, JULIE ANN
For authorized use by:
NH BOARD OF MEDICINE

JOHNSTON, JULIE ANN - ONE-TIME QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: JOHNSTON, JULIE ANN
Date of Birth: [redacted] **Gender:** FEMALE
Home Address: [redacted]
Social Security Number: [redacted] **DEA:** [redacted]
License: PHYSICIAN (MD), 231502, MA, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): THE WARREN ALPERT MEDICAL SCHOOL OF BROWN UNIV (2004)

B. QUERY INFORMATION

Statutes Queried: Title IV; Section 1921; Section 1128E
Query Type: This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name: NH BOARD OF MEDICINE (DBID ending in ...65)
Authorized Submitter: MURIEL LARIVIERE, SECRETARY, (603) 271-6935

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 11/01/2013

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

---------- **No Reports Found** ----------

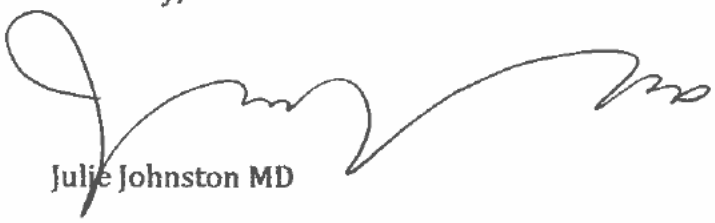
TEMP

10/2/13

Dear Sir or Madam:

Enclosed you will find my application for medical licensure in NH. I have completed the documentation for both a temporary and full license. Please let me know of any deficiencies so that they may be remedied in a timely fashion.

Sincerely,



Julie Johnston MD

RECEIVED
OCT - 4 2013
NH BOARD

2417
$50

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

US·MLE
United States Medical Licensing Examination

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 : 09/23/2013

RECEIVED
SEP 27 2013
NH BOARD

Recipient:

New Hampshire Board of Medicine
ATTN: Licensure
2 Industrial Park Drive
Suite 8
Concord, NH 03301-8520

Examinee: Johnston, Julie Ann
Alt Name(s): Johnston, Julie A

Examinee ID#: 5-105-034-2
Date of Birth: [redacted]

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		Comments
	06/18/2002	Pass	[redacted]	

USMLE STEP 2

Clinical Knowledge (CK)

	Test Date	Pass/Fail		Comments
	09/25/2003	Pass	[redacted]	

USMLE STEP 3

	Test Date	Pass/Fail		Comments
MASSACHUSETTS	08/03/2006	Pass	[redacted]	

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

JOHNSTON JULIE

Patent 5636874
TouchSafe®

SEE REVERSE SIDE FOR EXPLANATION OF INFORMATION REPORTED ABOVE.

Authenticity of USMLE Transcripts

An original, certified transcript of United States Medical Licensing Examination results is printed using black ink on blue safety paper and is produced only by the Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, or National Board of Medical Examiners. The TamperSafe® Hologram in the lower left corner certifies the authenticity of this document. Alteration or forgery of a USMLE transcript may result in appropriate legal action and/or a determination of irregular behavior, as described below.

To Test for Authenticity: Touch, rub or breathe on TouchSafe® Fingerprint and the word **VALID** will appear. When liquid bleach is applied to the face of the document, the paper will turn brown. Also, when photocopied, a security statement containing the words **UNOFFICIAL COPY, NOT AN ORIGINAL DOCUMENT**, will appear prominently across the face of the entire document.

INTERPRETATION OF RESULTS

USMLE transcripts include a complete examination history. On those Step examinations for which numeric scores are reported, a three-digit scale is used. Most scores fall between 140 and 260 on this scale. The recommended minimum passing score is shown on the front of the transcript next to the examinee's score for each administration along with a pass/fail outcome. Test results reported as passing represent an exam score of 75 or higher on a two-digit scoring scale. The level of proficiency required to meet the recommended minimum passing level for each USMLE Step is reviewed periodically and is subject to change. Such changes do not alter pass/fail outcomes from prior test administrations.

For examinations with reported scores, the Standard Error of Measurement (SEM) provides an index of the variation that would be expected to occur if an examinee were tested repeatedly using different sets of items covering similar content. The SEM is usually in the range of 4 to 8 points.

STEP 2 CLINICAL SKILLS (CS)

Step 2 CS results are reported as pass or fail, with no numeric score. Had the two-digit reporting scale been used, examinees would have had to achieve a score of 75 or higher in order to pass.

ANNOTATIONS APPEARING UNDER "COMMENTS"

Circumstances in connection with an administration shown on this transcript may result in one or more annotations listed next to the score. A description of each Comment is provided below:

Indeterminate - Results are at or above the passing level but cannot be certified as representing a valid measure of the examinee's knowledge or competence as sampled by the examination. **No score is reported.** Information regarding the nature of the indeterminate score is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Incomplete - The examinee sat for some, but not all, of the scheduled examination. **No score is reported.**

Irregular Behavior - The Committee for Individualized Review determined that the examinee engaged in irregular behavior. Examples of irregular behavior are described in the current edition of the *USMLE Bulletin of Information*. Information regarding the nature of the irregular behavior and the determination of the Committee is available. If such information is not enclosed with this transcript, it may be obtained by contacting the organization from which you received the transcript or the USMLE Secretariat, 3750 Market Street, Philadelphia, PA 19104, telephone (215) 590-9700.

Score Not Available - The score is not available. Further review and/or analysis may be pending, or it may have been determined that the score cannot be reported.

Test Accommodations - Following review and approval of a request from the examinee, test accommodations were provided in the administration of the examination.

ANNOTATIONS APPEARING AS "NOTE"

Circumstances not in connection with an administration shown on this transcript may result in one or more annotations and an explanation or instructions to contact the appropriate individual or organization. The Note will appear at the end of the document.

BOARD ACTION DATA BANK INFORMATION APPEARING AS "NOTE"

The Board Action Data Bank of the Federation of State Medical Boards (FSMB) contains actions reported to the FSMB by U.S. licensing and disciplinary boards, Canadian licensing authorities, the U.S. Armed Forces, the U.S. Department of Health and Human Services, and other credentialing entities. To be included in the Data Bank, an action must be a matter of public record or be legally releasable to state medical boards or other entities with recognized authority to review physician credentials. Certain actions reported to and released by the Board Action Data Bank are not disciplinary or otherwise prejudicial in nature. Such actions are reported to ensure that records are complete and to assist in preventing misrepresentation or the use of lost or stolen credentials by unauthorized persons. Once reported to the FSMB, an action becomes part of the permanent record of the individual physician, and the existence of such an action may be indicated on the USMLE transcript by a Note. 4/2013

New Hampshire Board of Medicine

2 INDUSTRIAL PARK DRIVE, SUITE 8, CONCORD, NH 03301-8520
Tel. (603) 271-1203 Fax (603) 271-6702
TDD Access: Relay NH 1-800-735-2964
WEB SITE: www.nh.gov/medicine

TEMPORARY LICENSE
#T- 0695

Pursuant to the New Hampshire Code of Administrative Rules, Med 301.03(c), a Temporary License is issued to:

Julie Ann Johnston, M.D.

The State of Massachusetts provided the New Hampshire Board of Medicine proof that Dr. Johnston holds a full unrestricted medical license in that state.

This license is effective for the period stated below:

November 6, 2013 through May 6, 2014.

Penny Taylor

Penny Taylor, Administrator

(SEAL)

Date: November 6, 2013

the DataBank

P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

DCN: 5500000087556198
Process Date: 02/21/2014
Page: 1 of 1
JOHNSTON, JULIE ANN
For authorized use by:
NH BOARD OF MEDICINE

JOHNSTON, JULIE ANN - ONE-TIME QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: JOHNSTON, JULIE ANN
Date of Birth: [redacted] **Gender:** FEMALE
Home Address:
Social Security Number: [redacted] **DEA:** [redacted]
License: PHYSICIAN (MD), 231502, MA, GENERAL PRACTICE/FAMILY PRACTICE
Professional School(s): THE WARREN ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY (2004)

B. QUERY INFORMATION

Statutes Queried: Title IV; Section 1921; Section 1128E
Query Type: This is a One-Time query response. Your organization will only receive future reports on this practitioner if another query is submitted.
Entity Name: NH BOARD OF MEDICINE (DBID ending in ...65)
Authorized Submitter: MURIEL LARIVIERE, SECRETARY, (603) 271-6935

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 02/21/2014

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

---------- **No Reports Found** ----------

JUN 23 2016

RECEIVED JUN 23 2016 NH BOARD

RECEIVED MAY 19 2016 NH BOARD

STATE OF NEW HAMPSHIRE

Telephone #: 603-271-6935

BOARD OF MEDICINE
121 South Fruit Street, Suite 301
Concord, NH 03301-2410

RENEWAL APPLICATION

For expiration on: 06/30/2018

Renewal Fee: $350.00

For Office Use Only: Date Pd: 5/19/16 Check # 2703

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

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

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

Specialty: FP

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

Currently licensed in the states of: (2 letter state abbrev.) MA

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

License #: 16515

File #: 17639

☐ Work Address

JULIE A JOHNSTON, MD
JOAN G LOVERING HEALTH CEN
PO BOX 456, 559 PORTSMOUTH A
GREENLAND, NH 03840-0456

☑ Home Address

[redacted]

Please provide current Email, Fax and Phone Numbers below:

Phone: 603-436-7588
Business Fax Number: 603-431-0451
Business Email Address: ***@***

Phone [redacted]

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

Hospital Privileges

LAWRENCE GENERAL HOSPITAL	LAWRENCE	MA

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate?		✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).	✓	
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: MA Expiration Date: 12/31/18	✓	

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

I HEREBY CERTIFY UNDER PENALTY OF UNSWORN FALSIFICATION THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

Signature of Licensee (Signature Stamp Not Accepted)

Date 5/13/16

OFFICE OF PROFESSIONAL LICENSURE AND CERTIFICATION
STATE OF NEW HAMPSHIRE
DIVISION OF HEALTH PROFESSIONS
121 South Fruit Street
Concord, N.H. 03301-2412
Telephone 603-271-1203 · Fax 603-271-6702

LOUISE LAVERTU
Executive Director

SARAH BLODGETT
Division Director

Please return renewal form when done. - password updated on 6/21/16 - Enrolled in 2015

SUBJECT: Two-Year Renewal - 7/1/2016 - 6/30/2018

_____ We are in receipt of your renewal application, however, there was no fee enclosed. Would you kindly send a check in the amount of $350.00, made payable to TREASURER, STATE OF NEW HAMPSHIRE.

_____ We are returning your renewal Application. The following information is missing:

_____ Email address _____ Business Phone Number _____ Business Fax Number _____ Home Phone Number

_____ We are returning your check - please sign it and return to this office.

_____ We are returning your renewal Application - please sign where indicated.

_____ You have answered YES in the space indicated on the back of this Application. Please send to the Board all pertinent information as soon as possible. Your license cannot be renewed without this information.

_____ We are returning the copy of your renewal application. According to Med 401.03 Renewal Application, "The licensee shall file a renewal application **provided by the Board……**"

_____ We have been notified that you have not fulfilled your CME requirements. We are sorry we cannot process your renewal application until this matter is cleared up. **M.D.s and D.O.s please call the N.H. Medical Society at (603) 224-1909.**

_____ Your application was returned to the Board due to an erroneous address. Pursuant to the New Hampshire rules and laws, within 30 days of any address change, you are required to inform the Board, in writing, of your principal address to which all official Board communications shall be directed. Please complete the enclosed renewal application, indicating any new addresses, and return to the Board with the required renewal fee.

X You have indicated you have not registered with the NH Prescription Drug Monitoring Program (NH PDMP), however, you hold a DEA license. You are required to be registered with the NH PDMP prior to renewing your license. Please contact the Help Desk at 1-855-353-9903 to become registered.

_____ Your renewal is being returned for a separate reason. Please consider completing the NH Division of Public Health's Physician Licensure Survey (NHPH Survey). Please contact Danielle Weiss at Danielle.Weiss@dhhs.state.nh.us or (603) 271-4547.

_____ If your renewal is postmarked after June 30, 2016 you will be required to pay the additional $350 late fee.

_____ ***Your renewal was postmarked after June 30, 2016. You are therefore required to pay the additional $350.00 late fee. See below.

***PLEASE BE ADVISED THAT YOUR *COMPLETED* RENEWAL APPLICATION WAS NOT IN THIS OFFICE BY JUNE 30, 2016 OR POSTMARKED BY JUNE 30, 2016, THEREFORE, YOUR LICENSE EXPIRED EFFECTIVE JULY 1, 2016 AND YOU ARE NOT PERMITTED TO PRACTICE MEDICINE IN NEW HAMPSHIRE UNTIL THE LICENSE IS RENEWED. *COMPLETED* RENEWAL APPLICATION MEANS THE APPLICATION IS COMPLETELY FILLED OUT AND SIGNED, YOUR CONTINUING MEDICAL EDUCATION (CME) IS UP-TO-DATE AND THE RENEWAL FEE IS PAID.

X Other Please register or finish registering for the NH PDMP

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

May 16, 2016

To Whom It May Concern:

This letter verifies Julie A Johnston, M.D. (NPI: 1033317276) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 20, 2007 - Dec 31, 2017*

* Three Year extension of certification earned by completion of MC-FP requirements.

Maintenance of Certification for Family Physicians (MC-FP):

Current Status: Meeting Requirements

Beginning in 2004 with the family physicians who performed successfully on the Certification and Recertification examinations in 2003, the ABFM began a gradual transition from Recertification to Maintenance of Certification for Family Physicians (MC-FP). MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

The MC-FP program is divided into separate three-year stages. By completing Stage 1 and Stage 2 by specified deadlines, the life of a certificate will be extended from seven to ten years. Diplomates who are unable to complete these requirements will retain their original seven-year certificate. Regardless of whether a Diplomate is on a 10-year or 7-year cycle, MC-FP requirements must be completed prior to applying for the next MC-FP examination. The prior requirements for licensure and CME are incorporated into the requirements of MC-FP.

The ABFM website serves as primary source verification. Details of the MC-FP process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant

Julie Johnston MD
Practice Locations

Clinician
Greater Lawrence Family Health Center
34 Haverhill Street
Lawrence, MA 01841
978-686-0090

Medical Director
Health Quarters Inc.
(Admin office)
100 Cummings Center
Suite 220B
Beverly, MA 01815
978-927-9824

RECEIVED
APR 23 2018

STATE OF NEW HAMPSHIRE MAY 07 2018

Telephone #: 603-271-6935

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

RENEWAL APPLICATION

For Office Use Only: Date Pd: 4/23/18 Check # 2902

For expiration on: 06/30/2020 Renewal Fee: $350.00

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

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

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

Specialty: Family Practice/Family Medicine
Currently Board Certified? (Y/N) Yes **(If yes, provide proof of board certification.)**
Please list ABMS Board Specialty: American board of Family Medicine
Currently licensed in the states of: (2 letter state abbrev.) MA, NH

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

License #: 16515

☒ Home Address

JULIE A JOHNSTON, MD
[redacted]

☐ Work Address

JULIE A JOHNSTON, MD
JOAN G LOVERING HEALTH CENTER
PO BOX 456, 559 PORTSMOUTH AVE
GREENLAND NH 03840-0456

Please provide current Email, Fax and Phone Numbers below:

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

PHONE: 6034367588
FAX: 603-431-0451
EMAIL: [redacted]

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

LAWRENCE GENERAL HOSPITAL LAWRENCE MA

(RENEWAL APPLICATION CONTINUED ON REVERSE SIDE)

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

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

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

	YES	NO
1. With regard to any and all Boards or licensing bodies with which you hold or have held a license to practice medicine, have you been subject to any disciplinary action, limitation or restriction on your license, or entered into any agreement with a licensing body for any reason, including but not limited to rehabilitation?		✓
2. Have you been denied a license to practice medicine, or have you surrendered a license due to an investigation or disciplinary action, in any state other than New Hampshire?		✓
3. Have you been subject to any investigation or to a denial, restriction, suspension, loss or revocation of your U.S. Drug Enforcement Agency ("DEA") certificate?		✓
4. Have you been treated, other than through the N.H. Professionals Health Program, for abuse or misuse of any chemical substance, including alcohol?		✓
5. Have you had any emotional disturbance or mental or physical illness which has impaired your ability to practice medicine?		✓
6. Have you been found guilty or entered a plea of no contest to any felony, misdemeanor or alcohol or drug related offense that has not been annulled by a court?		✓
7. Have you been reported to the National Practitioner's Data Bank? If yes, please submit a copy of the report.		✓
8. Have you been the subject of an investigation or disciplinary proceeding regarding the practice of medicine? Please exclude investigations and disciplinary proceedings conducted by the New Hampshire Board of Medicine.		✓
9. Have any hospital privileges been suspended, limited or denied other than for medical records violations, or have you been placed on administrative or medical leave?		✓
10. Have any medical malpractice claims been made against you? See attached reporting form.		✓
11. Are you practicing in any other location other than the principal business address listed on the front of this renewal? If so, please attach a list with all additional business address(es) and business phone number(s).	✓	
12. Have you registered with the Controlled Drug Health and Safety Program (also known as the N.H. Prescription Drug Monitoring Program)?	✓	
13. Do you have a DEA license number? If so, please provide the state of issuance and the expiration date. State of Issue: MA Expiration Date: 12/31/18	✓	

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

I HEREBY CERTIFY UNDER PENALTY OF UNSWORN FALSIFICATION THAT ALL INFORMATION ON THIS FORM IS CURRENTLY ACCURATE. **I acknowledge that I am governed by the Medical Practice Act (RSA 329), the New Hampshire Code of Administrative Rules (Med 100-500), and the American Medical Association's Code of Medical Ethics. I have familiarized myself with these documents and acknowledge that deviation from the standards set therein may subject me to disciplinary action by the N.H. Board of Medicine.**

[signature] MD
Signature of Licensee (Signature Stamp Not Accepted)

4/9/18
Date

Additional Work locations:

Greater Lawrence Family Health Center
34 Haverhill Street
Lawrence, MA 01841
978-686-0090

Health Quarters Inc.
100 Cummings Center
Suite 220B
Beverly, MA 01815
978-927-9824

American Board of Family Medicine, Inc.

Quality Healthcare, Public Trust . . . Setting the Standards in Family Medicine

April 09, 2018

To Whom It May Concern:

This letter verifies Julie A Johnston, M.D. (NPI: 1033317276) is currently certified with the American Board of Family Medicine (ABFM).

Family Medicine Certification History:

Jul 20, 2007 - Apr 12, 2017
Apr 13, 2017 - * Certification Number: 1069596033

* Certification is continuous as long as Family Medicine Certification Requirements are maintained.

Family Medicine Certification Requirements:

Current Status: Meeting Requirements

Beginning in 2011 certification by the American Board of Family Medicine is maintained through successful completion of the Family Medicine Certification process. The Family Medicine Certification process is a continuous process that requires being in compliance with Guidelines for Professionalism Licensure and Personal Conduct including maintaining a currently valid, full, and unrestricted license to practice medicine in the United States or Canada, completing certification activities in a timely fashion, and performing successfully on the examination every ten years. Failure to maintain any of these requirements will result in the loss of certification status with the ABFM. Based upon the continuous nature of Family Medicine Certification, no end date for certification is presented above.

In 2003 family physicians who performed successfully on the Certification and Recertification examinations began a gradual transition from Recertification to MC-FP. MC-FP was designed to transition all Diplomates into the program by 2010, enrolling all physicians who certified or recertified as they successfully passed the examination.

The ABFM website serves as primary source verification. Details of the Family Medicine Certification process are available online at www.theabfm.org.

Sincerely,

Mary McIntosh

Mary McIntosh
Verification Coordinator and Candidate Assistant