Cheryl Hamlin, MD

Licensed Physician #MD2022-1011

Issue Date	Expiration Date
07/19/2022	07/01/2023

Signature of Holder

The bearer is prohibited by law from using this identification card to give the impression that they are in any way connected with a governmental agency.

New Mexico Medical Board

Triennial Renewal Certificate

This is to certify that

Cheryl Hamlin, MD

License Number: MD2022-1011

Having complied with the provisions of the Medical Practice Act is hereby granted a license to practice in the State of New Mexico as a Physician.

Issue Date: 07/19/2022 Date Expires: 07/01/2023*

A New Mexico medical license that has not been renewed by July 1 of the renewal year will remain temporarily active with respect to medical practice until September 30 of the renewal year at which time, the status will be changed to lapsed. A lapsed license is not valid for practice in New Mexico.

This License Must Be Conspicuously Posted In Each Practice Location

HSC

The New Mexico Physician and Practitioner Credentials Application ©

Physician Application

THE NEW MEXICO MEDICAL SOCIETY

Applying for Telemedicine Licensure? ☐ Applying for first ever Full Physician License in any state? ☐

****ALL FEES ARE NON-REFUNDABLE****

If this application is incomplete upon one (1) year of receipt, the application and supporting documentation will become dormant, and application will become null and void.

Date of Application: 4/8/2022 Application Fee: $400.00

PayPal Confirmation: [redacted] TOTAL: $400.00

R2455499

Name: Cheryl Hamlin

Title: MD Other: Maiden or Other Names Used

Applying using: ☑ NMMB ☐ HSC ☐ FCVS

What are your NM practice plans? Currently working with colleague to set up a practice.

Gender: Female Citizenship: United States Place of Birth: Illinois

Social Security Number: [redacted] Date of Birth: [redacted]

State Tax ID#: MA ☐ Pending Fed. Tax ID#: ☐ Pending

Medicare#: ☐ Pending Medicaid #: ☐ Pending

Unique Physician Identification Number (UPIN): ☐ Pending

National Provider Identifier Number (NPI): [redacted] ☐ Pending

CLIA Number (if applicable): Approval Level: Expiration Date:

Home Address

Street Address: [redacted]

City, State/Province and Zipcode: Arlington, MA, 02138

Country: United States

Telephone Number: [redacted] Pager Number:

Cell Phone Number: Spouse's Name (Optional): [redacted]

Credentials Correspondence Address

Department:

Street Address: 330 Mount Auburn St

City, State/Province and Zipcode: Cambridge, MA, 02138

Country: United States Email: chamlin@mah.harvard.edu

Telephone Number: 617-499-5161 Facsimile Number:

Military Service

Branch: Type of Discharge:

Dates: From: To: ☐ Current Rank:

Immigration

Status: Certification Number:

ECFMG (Educational Commission for Foreign Medical Graduates)

Number (if applicable): Date Issued: (Please attach a copy of your ECFMG certificate)

Languages

Foreign Languages (spoken fluently by practitioner): English/ Spanish

Certifications

ACLS CERTIFICATION			ATLS CERTIFICATION			PALS CERTIFICATION		
Certified?	☑ Yes	☐ No	Certified?	☐ Yes	☑ No	Certified?	☐ Yes	☑ No
Expires:	2/23/2023		Expires:			Expires:		

HOSPITAL AND HEALTHCARE AFFILIATIONS

☐ Are you a PCP? ☑ Do you deliver babies? ☑ Are you an MD, DO, or DPM?

If you answered yes to any question above, you must:
(a) Have admitting privileges at a hospital (list below) OR
(b) Provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

☐ Do you have courtesy or consulting privileges at this facility.
☐ If yes, do these courtesy or consulting privileges allow you to admit patients.

If no, provide a written explanation as to the arrangements you have made with a physician to admit your patients, along with a signed letter from that physician confirming the arrangements, and the name of the facility where your patients will be admitted.

I deliver babies in MA but am not planning to in NM

Please list all hospital staff membership and/or healthcare organization affiliations in the past fifteen (15) years, and your status (active, courtesy, consulting, etc.) If an institution is no longer in existence, please provide an alternative source of verification. Attach a separate page if necessary.

Facility Name: Mount Auburn Hospital* ☑ Is this your primary admitting facility

Department: Medical Staff Affairs

Street Address: 330 Mount Auburn St

City: Cambridge State/Province: MA Zip Code: 02238

Country: United States

Phone Number: 617-492-3500 Facsimile: 617-499-5575

Appointment Dates From: 07/2008 To: ☑ Present

Type of Appointment: Active/Faculty

WORK HISTORY

Please list all previous experience for the past fifteen (15) years, including months and years, listing the most recent first. Attach a separate page if necessary. Please attach a current CV or resume.

Organization: Planned Parenthood SE From: 01/2021 To: ☑ Present

Department:

Street Address: 1019 1 st AVE N

City: Birmingham State/Province: AL Zip Code: 35203

Country: United States Phone Number: 2-053-222-1212

Contact: Fax Number:

Type of Practice: Part-time

Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Jackson Women's Health Organization From: 09/2017 To: ☑ Present
Department:
Street Address: 2903 N State St
City: Jackson State/Province: MS Zip Code: 39216
Country: United States Phone Number: 601-366-2261
Contact: Fax Number:
Type of Practice: Active/Part-time

Please provide written explanation for any gaps in work history of six (6) months or more.

Organization: Women's Health Service From: 01/2017 To: ☑ Present
Department:
Street Address: 111 Harvard St
City: Brookline State/Province: MA Zip Code: 02446
Country: United States Phone Number: 617-277-0009
Contact: Fax Number:
Type of Practice: Part-time

Please provide written explanation for any gaps in work history of six (6) months or more.

Work history gap explanations follow:

PRACTICE LOCATIONS

Group Name: Mount Auburn Ob/gyn Assoc. Effective Date: 7/2008
Department:
Street Address: 330 Mount Auburn Street
City: Cambridge State/Province: MA Zip Code: 02318
Country: United States
Phone Number: 617-499-5161 Facsimile Number:
Email Address: ehuang3@mah.harvard.edu Answering Service Number: 617-499-5151
Foreign Languages (spoken fluently at practice): spanish
Office Manager or Contact Person: Ed Huang Phone: 617-499-5161

Billing Address

Billing Information same as practice information

Practice Associates (if applicable): Call Coverage (if applicable):

_____ / _____

_____ / _____

_____ / _____

What are the office hours for your Practice or Group Practice? (Provide days/hours):
What provisions have been made for after hours?:

CONTINUING EDUCATION

1. If you are applying for privileges at a hospital or clinic, please attach documentation of all continuing education hours you have obtained in the last two(2) years or complete the attached statement of continuing medical education.

2. If you are applying for privileges at a hospital or clinic, please complete the enclosed privilege request form and ensure that you include any additional privileges that you are requesting. This will ensure your application is considered based upon the most accurate information available.

PROFESSIONAL REFERENCES

Please list five (5) professional peers with the same type of license, or a higher level of licensure, who are familiar with your professional performance in the past three (3) years.

Name and Title: [redacted] Specialty: obstetrics gynecology
Department: Mount Auburn Ob/GYN Associates
Street Address: 330 Mount Auburn St
City: Cambridge State/Province: MA Zip Code: 02138
Country: United States Email: [redacted]
Phone Number: [redacted] Facsimile Number:

Name and Title: [redacted] Specialty: Gynecology
Department: Women's Health Services
Street Address: 111 harvard st
City: Brookline State/Province: MA Zip Code: 02446
Country: United States Email: [redacted]
Phone Number: [redacted] Facsimile Number:

Name and Title: [redacted] Specialty: Obstetric and Gynecology
Department: Mount Auburn ob/gyn Associates
Street Address: 330 Mount Auburn Street

City: Cambridge
State/Province: MA
Zip Code: 02138
Country: United States
Email: [redacted]
Phone Number: [redacted]
Facsimile Number:

Name and Title: Malcom Mackenzie MD
Specialty: Obstetric and Gynecology
Department: Mount Auburn ob/gyn Associates
Street Address: 330 Mount Auburn St
City: Cambridge
State/Province: MA
Zip Code: 02138
Country: United States
Email: mmacken1@mah.harvard.edu
Phone Number: 617-499-5151
Facsimile Number:

Name and Title: Sacheen Carr-Ellis MD
Specialty: Gynecology
Department: Jackson Women's Health Organization
Street Address: 2903 N State st
City: Jackson
State/Province: MS
Zip Code: 39216
Country: United States
Email: scarrellis@gmail.com
Phone Number: 601-366-2261
Facsimile Number:

LICENSURE REGISTRATION INFORMATION

List all licenses held in all jurisdictions. Attach a separate page if necessary.

State Professional License/Certification Number: 38877
☐ Pending
State: Alabama
Issue Date: 1/1/2020
Expiration Date: 12/31/2022

State Professional License/Certification Number: 74421
☐ Pending
State: Massachusetts
Issue Date: 6/26/1991
Expiration Date: 6/15/2022

State Professional License/Certification Number: 25003
☐ Pending
State: Mississippi
Issue Date: 5/26/2017
Expiration Date: 6/30/2022

LICENSING EXAM

Please check all that apply:

☐ State Board Exam (Prior to 1973) Which State? Date(s) passed?
☐ FLEX

Part/Step 1 Date Passed
Part/Step 2 Date Passed
Part/Step 3 Date Passed

☐ LMCC

Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed	

☑ NBME (MD Only):

Part/Step 1 Date Passed	6/10/1986	Part/Step 2 Date Passed	9/29/1987	Part/Step 3 Date Passed	5/16/1990

☐ NBOE (DO Only):

Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed	

☐ COMPLEX (DO Only):

Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed	

☐ USMLE

Part/Step 1 Date Passed		Part/Step 2 Date Passed		Part/Step 3 Date Passed	

DRUG CERTIFICATION INFORMATION

Federal Drug Enforcement Administration (DEA) Registration: ☐ N/A

DEA Number: [redacted] Expiration Date: 10/29/2022 ☐ Pending

DEA Number: [redacted] Expiration Date: 10/29/2024 ☐ Pending

DEA Number: [redacted] Expiration Date: 10/29/2023 ☐ Pending

State Controlled Substance Registration (CSR): ☐ N/A

CSR Number: [redacted] Expiration Date: 12/31/2022 State: Alabama ☐ Pending

CSR Number: [redacted] Expiration Date: 12/12/2022 State: Massachusetts ☐ Pending

EDUCATION

List all medical, osteopathic, dental or podiatric schools attended for graduate education and list all hospitals where you received training for post - graduate training. Attach a copy of your certificate. Disclose every residency program initiated, whether completed or not, and all completed programs. Attach a separate page if necessary.Check the type of education listed.

Degree Level: Graduate

Institution: Harvard School of Public Health

Department: Registrar's Office

Street Address: 665 Huntington Ave

City: Boston State/Province: MA Zip Code: 02115

Country: United States

Degree Earned: MPH - Master of Public Health

If teaching appointment: Department/Position

Dates Attended:

From: 8/1992

To: 6/1994

Graduation Date: 1994

or Specialty: Public Health

Degree Level: Residency
Institution: Boston University Medical Center
Department: Obstetrics and Gynecology Residency Program
Street Address: 85 E Concord Street 6th Floor
City: Boston State/Province: MA Zip Code: 02118
Country: United States
Degree Earned: RES - Residency
If teaching appointment: Department/Position

Dates Attended:
From: 7/1988
To: 7/1992
Graduation Date: 1992
or Specialty: Obstetrics/Gynecology

Degree Level: Graduate
Institution: university of Illinois medical school
Department:
Street Address: 1601 Parkview Ave.
City: Rockford State/Province: IL Zip Code: 61107
Country: United States
Degree Earned: MD - Doctor of Medicine
If teaching appointment: Department/Position

Dates Attended:
From: 6/1984
To: 6/1988
Graduation Date: 1988
or Specialty: Medicine

Degree Level: Faculty
Institution: Harvard Medical School
Department: Attn: Registrar's Office
Street Address: 25 Shattuck St Room A-111
City: Boston State/Province: MA Zip Code: 02115
Country: United States
Degree Earned: MD - Doctor of Medicine
If teaching appointment: Department/Position

Dates Attended:
From: 7/2008
To: Present
Graduation Date:
or Specialty: Obstetrics/Gynecology

SPECIALTY BOARD CERTIFICATIONS

NOTE: If you are not board certified by the American Board of Medical Specialties or the American Osteopathic Association, or accepted for examination in your specialty, please give brief explanation on the attached sheet.

☑ Board or ☐ Specialty Board Name: American Board of Obstetrics and Gynecology
Date Certified: 11/01/1995 Date Last Recertified: Expiration Date: 12/31/2022 ☐ Lifetime
Certification Number: 928556

MEDICAL MALPRACTICE INSURANCE

Do you have current medical malpractice insurance? ☑ Yes ☐ No

Please list medical malpractice insurance carriers for the past five (5) years. Attach a separate page if necessary.

Carrier: CRICO
Limits: 1000000.00, 5000000.00
Department: Claims History
Street Address: 1325 Boylston Street
☐ Pending
City, State/Province and Zipcode: Boston, MA, 02215
Country: United States
Dates Insured: From: 01/01/2022 To: 12/31/2022 Policy Number: MTAH-CRICO-GLPL-1709-2022

Carrier: Admiral Insurance (A Berkley Company)
Limits: 1000000.00, 3000000.00
Department: Claims Verifications
Street Address: PO Box 5430
☐ Pending
City, State/Province and Zipcode: Mount Laurel, NJ, 08054
Country: United States
Dates Insured: From: 04/18/2021 To: 04/18/2022 Policy Number: CO000005712-01

PROFESSIONAL PRACTICE QUESTIONS

Read carefully before answering questions.

A. You must answer all questions. You must provide explanatory information –

- for any "yes" answer to questions numbered 1-18 and
- for any "no" answer to questions numbered 19-23.

Your failure to provide full and accurate details for any or all of those answers may result in disciplinary action or denial of your application. If in doubt, disclose.

B. The Board expects full and accurate disclosure of all information. You must update any information that changes while your application is pending.

C. The term "you" means you personally and any healthcare entity for which you serve as a business owner, officer or medical director.

Licensing & Professional Membership		
1.a. *Regardless of the outcome,* have you been subject to investigation by a licensing board or other government entity that resulted or could have resulted in any type of sanction (e.g., fine, reprimand, suspension, revocation, limitation, probation)?	☐ Yes	☑ No
1.b. Is any license you now hold under investigation or being challenged?	☐ Yes	☑ No
2. Have you ever been denied membership or renewal, or been subject to investigation or discipline, by a professional organization?	☐ Yes	☑ No
3. Has a federal or state controlled substance registration issued to you ever been voluntarily or involuntarily restricted, limited, suspended, or revoked?	☐ Yes	☑ No
Education		
4. Have you, for any reason, ever		
4.a. been suspended, dismissed, terminated, resigned or withdrawn from a medical school or postgraduate training (PGT) program?	☐ Yes	☑ No
4.b. been placed on probation or remediation by a medical school or PGT program?	☐ Yes	☑ No
4.c. taken a leave of absence or break from, had any interruption to, or any extension of a medical school or PGT program (reasons might include illness, disability, pregnancy or parental leave, academics, military service)?	☐ Yes	☑ No
Privileges/Appointments		
5.a. For any reason, have your privileges at any healthcare entity ever been subject to investigation, which resulted in a voluntary or involuntary restriction, reduction, suspension, surrender, revocation or non-renewal of your privileges?	☐ Yes	☑ No
5.b. Have you ever agreed to limit or not to exercise your clinical privileges while under investigation?	☐ Yes	☑ No
6. Have you ever been disciplined or suspended by any healthcare entity with which you have been employed, or resigned in lieu of investigation or other action?	☐ Yes	☑ No
7. Have you ever been subject to a request for corrective action by a healthcare entity where you held appointment as a member of the medical staff?	☐ Yes	☑ No
Insurance/Health Care Plans		
8. Has any private or government health plan or network, e.g., a private healthcare insurance provider, Medicare, Medicaid, ever limited, sanctioned or terminated you as a provider?	☐ Yes	☑ No
Liability		
9. Has your professional liability coverage ever been terminated by action of the insurance company, except as a result of the company ceasing to offer insurance to physicians?	☐ Yes	☑ No
10. Have you ever been denied professional liability insurance coverage?	☐ Yes	☑ No
11. Has your professional liability insurance carrier ever excluded any procedures from your coverage?	☐ Yes	☑ No

12. Within the past ten (10) years, have you ever been involved in a public or private settlement, or a medical malpractice claim or suit, or been notified in writing of the intent to file a malpractice suit? **If yes, please complete the attached Malpractice History Form for each case.**	☑ Yes	☐ No
13. Have you ever been reported to the National Practitioner Data Bank (NPDB)?	☐ Yes	☑ No
Ethics/Impairment		
14. Regardless of the outcome and the status of the proceeding, have you ever been arrested or named as a defendant in any criminal action, e.g., convicted, acquitted, dismissed, vacated, sealed, expunged, appealed?	☐ Yes	☑ No
15.aDuring the past five (5) years, have you engaged in any behavior(s) or used any substance(s) (e.g., alcohol, street drugs, prescription medications) in a manner characteristic of an addiction disorder?	☐ Yes	☑ No
15.bAre you now engaging in any behavior(s) or using any substance(s) (e.g., alcohol, street drugs, prescription medications) in a manner characteristic of an addiction disorder?	☐ Yes	☑ No
15.cHave you been diagnosed with or treated for an addiction disorder at any time during the past five years (including the present)?	☐ Yes	☑ No
16. Are you now, being treated with any opioid analgesic(s) for chronic pain? If yes, please provide a current neuropsychological evaluation and written clearance to practice from your treating physician. See Rule 16.10.14.10.	[redacted]	
17. Do you have, or have you been diagnosed with, an illness or condition which impairs your judgment or affects your ongoing ability to practice medicine in a competent, ethical and professional manner? **If yes, please have your treating physician send the NM Medical Board a letter regarding your diagnosis, treatment, and current status.**	[redacted]	
18. Are you currently out of compliance with a judgment and order for child support in New Mexico?	☐ Yes	☑ No
Attestations		
19. I attest I will limit my practice to areas in which I am competent to practice.	☑ Yes	☐ No
20. I attest I understand I have a continuing duty to report any adverse action taken against me or my license as required by Board Rule Part 16.10.10 NMAC.	☑ Yes	☐ No
21. I attest I have reviewed the completed form and the information it contains is complete and accurate.	☑ Yes	☐ No
22. I attest I have provided a reliable and reasonable address for correspondence to be sent to me by the Board and will notify the Board of any address changes.	☑ Yes	☐ No
23. I attest I will adhere to AMA's ethical standards and the principles of professionalism, honesty and respect for the law at all times.	☑ Yes	☐ No

If you answered "YES" to questions 1-18, and/or "NO" to questions 19-23, please provide a detailed written explanation for each of those answers with this application.

Professional Practice Questions - Explanations

12.: please see malpractice history form

New Mexico Medical Board
2055 S. Pacheco St. Bldg. 400
Santa Fe, NM 87505 (505) 476-7220

4/11/22

RECEIVED
APR 19 2022
NM MEDICAL BOARD

APPLICANT'S OATH

I, Cheryl Hamlin, **hereby certify that I am the person pictured below and named in this application for a license to practice as a Physician in the State of New Mexico; that all statements I have made herein are true; that I am the original and lawful possessor and person named in the various forms and credentials furnished to the New Mexico Medical Board (Board) with my application.**

I acknowledge and state that I have read the Information and Instructions that accompanied this application and I have answered all questions truthfully. I understand that the fee I submitted is not refundable.

I authorize and request every person, hospital, clinic, community, governmental agency, court, association, institution or other organization having 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 their 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, and their agents or representatives, and any person furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records, other information, or the investigation made by the Board. I authorize the Board to release information, material, documents, orders, or the like relating to me or to this application to any other agency of the State of New Mexico or the appropriate licensing agency of any other state or Territory of the United States or any agency of the United States government.

Applicant Signature _____ Date 4/7/22

*Passport-quality color photograph taken within six months prior to filing the application, approximate size 2 x 2 inches, head and shoulders only, full face, front view, plain white or off-white background, standard photo stock paper, scanned or computer-generated photographs should have no visible pixels or dots.

Applicant Name Cheryl Hamlin **Date** 4/7/22

Date 4/24/2022

Cheryl L Hamlin

Office Address: Mount Auburn Hospital
Department of Ob/Gyn
330 Mount Auburn Street
Cambridge, MA 02139

Home Address: [redacted]
Arlington, MA 02476

Home phone [redacted]
Work email
Work fax
Place of Birth Harvey, IL

Education

1988	BS	Biology	University of Illinois
1988	MD		University of Illinois
1994	MPH	Maternal Child Health	Harvard School of Public Health

Postdoctoral Traning

1988-1992	Residency in Obstetrics and Gynecology	Boston Medical Center One Boston Medical Center Place Boston, MA 02118

Faculty Academic Appointments

1992-present	Instructor Harvard School of Medicine	Obstetrics and Gynecology	Harvard Medical School
	Instructor School of		

2019-Present	Medicine	Obstetrics and Gynecology	Boston University School of Medicine

Appointments at Hospitals /Affiliated Institutions

1992-1996	Faculty	Obstetrics and Gynecology	Mount Auburn Hospital Cambridge, MA
1996-2007	Faculty	Obstetrics and Gynecology	Cambridge Hospital Cambridge ,MA
2008-present	Faculty	Obstetrics and Gynecology	Mount Auburn Hospital Cambridge, MA
2008-present	Credentialed	Obstetrics and Gynecology	Charles River Community Health Center
2020-present	Credentialed	Gynecology	Planned Parenthood, South East

Other Professional Positions

2017-present	staff	Women's Health Service Brookline, MA
2017-present	staff	Jackson Women's Health Organization. Jackson, MS

Committee Service

Local

Clinical Education Core Group	Mount Auburn Hospital
Clinical Service Committee	Mount Auburn Hospital
Peer Support Committee	Mount Auburn Hospital
Global Health Interest Group	Mount Auburn Hospital

Ethics Committee		Mount Auburn Hospital

Regional

2015- 2021	Board Member Gynesim	Non profit that develops models for simulation training for minimally invasive surgery

International

2008-present	Board Member Maya Midwifery International	501c charity dedicated to assisting indigenous Mayan Midwives
2019- present	Board Member Arlington Teosinte Sister City Project	Organization that promotes Community between cities

Local Teaching and Training

1996-2006	OB/GYN core Clerkship 3rd year Tufts Medical Students	3 hours /week	Cambridge Health Alliance
2005-2006	Primary Preceptor 3rd year Harvard Integrated Clerkship	5 hours/week	Cambridge Health Alliance
1992-1996	OB/GYN core Clerkship 3rd year Harvard Medical Students	3 hours/week	Mount Auburn Hospital
2008-present	OB/GYN core Clerkship 3rd year Boston University and Harvard Medical Students	10 hours/week	Mount Auburn Hospital
2014 2013-present	Patient-Doctor II Oral Exams 3rd year Harvard Medical Students	5 hours/year 20 hours/year	Harvard Medical School Beth Israel Deaconess Medical Center
2014	HST functional Human Anatomy Female Pelvic Model Building Exercise	4 hours	Harvard Medical School

1996-2006	Supervising Tuft Residents PGY 2 and PGY3 Labor and Delivery and OR	20 hours /year	Cambridge Health Alliance
2008-present	Supervising BIDMC PGY 3 residents OR	20 hours/year	Mount Auburn Hospital
2008-present	Attending at Sharewood Free Clinic supervising first and second year Tufts medical students	12 hours /year	Sharewood Clinic Malden, MA

Current LIsensure and Certification

1988-present	Medical License	State of Massachusetts
2017-present	Medical License	State of Mississippi
2020 - present	Medical License	State of Alabama
1995-present	Certified	American Board of Obstetrics and Gynecology

Practice Activities

1992-1996	Faculty	Obstetrics and Gynecology	Mount Auburn Hospital Cambridge,MA
1996-2007	Faculty	Obstetrics and Gynecology	Cambridge Hospital Cambridge, MA
2008-present	Faculty	Obstetrics and Gynecology	Mount Auburn Hospital Cambridge, MA
2008-present	Credentialed	Obstetrics and Gynecology	Charles River Community Health Center , Brighton and Waltham, MA
2017-present	staff		Women's Health Service Brookline , MA
2017-present	staff		Jackson Women's Health Organization. Jackson, MS

Clinical Innovations

Spearheaded the introduction of group prenatal care at Charles River Community Health Center

Worked with diabetic nurse and nutrition staff at Charles River Community Health Center to find creative ways to improve compliance for patients with gestational and preexisting diabetes.

Report of Education of Patients and Service to the Community

Helped to organize group prenatal care at Charles River Community Health Center

Volunteer at Sharewood Free Health Clinic

I have volunteered at Rosie's Place in Boston, Both serving meals as well as teaching English as a second language.

2008 I received my certificate in teaching English as a second Language through Boston Language Institute

1988 Traveled to Zaire as a fourth year medical student. I worked in a rural hospital providing a wide range of services.

2006-2007 Traveled to Kenya twice to perform gynecologic surgery in a rural hospital. I also covered the maternity unit and rounded on all wards gaining invaluable experience seeing infections specific to a tropical region. I also worked in a mobile clinic in an orphan feeding program, caring for orphans of HIV.

2007-I traveled to Haiti with Partners in Health for one week to perform gynecologic surgery

2006-present - I have worked with Maya Midwifery International. I am a board member. I have participated in organizational and fundraising events. I have traveled to Guatemala several times, providing supervision, education and support to the local midwives at the center and on mobile clinics. I have worked closely with local midwives. In addition to providing a service, I was able to learn from the midwives their approach to health care with limited resources.

2012- I traveled to Guatemala with Partners in Health, helping to develop a cervical cancer screening program.

2015- I traveled Uganda to a small rural hospital to support and advise their current women and maternal health program. I also saw patients and performed gynecologic surgery.

2018-I traveled to Chiapas, Mexico with Partners in Health to work with and support providers in a small community hospital.

RISK MANAGEMENT FOUNDATION

Board of Registration Report

From January 1, 2018 through January 31, 2018

Claim No.	00029951
Insurer:	01
Organization:	PROSER-MTAH MOUNT AUBURN PROFESSIONAL SERVICES, INC.
Social Security No.	[redacted]
Physician Last Name:	HAMLIN
Physician First Name:	CHERYL
Physician Middle Name:	L.
License(s):	**License No.** **State**
	74421 MA
Sponsor:	MTAH MOUNT AUBURN HOSPITAL
Defendant Policy Number:	MTAH-CRICO-C-GLPL-1368-2014
Physician Speciality	90001
Injury Loss Date:	Mar 16, 2012
Ocurrence Location:	021 LABOR & DELIVERY
Claimant Sex	FEMALE
Claimant Age:	0 day old
Description:	FEMALE PATIENT AT 29 WEEKS OF PREGNANCY WITH PREECLAMPSIA WAS DELIVERED PREMATURELY DUE TO ACUTE ABRUPTION RESULTING IN CHILD WITH CEREBRAL PALSY AND SERIOUS NEUROLOGIC DEFICITS.
Disposition:	50 SETTLED DURING TRIAL
Cumulative Ind. Paid:	4,800,000
Indemnity Paid:	1,200,000
Close Date:	Jan 16, 2018
Claimant Last Name:	[redacted]
Claimant First Name:	[redacted]
Claimant Middle Name:	
Claimant D.O.B:	[redacted]
Claimant Zip:	02451
Court Jurisdiction:	ST
Docket Number:	[redacted]
Case Name:	[redacted]

Form-R

14-16) Form-R Section A and B:

Incident 1:

Section A:

Insurer (at the time of incident):	CRICO
Policy Number:	MTAH-CRICO-C-GLPL-1530-2018
Patient Name:	[redacted]
Claimant Name (if different from Patient):	
Incident Date:	3/16/2012
Allegation(s):	Delay in diagnosis

Section B:

Case Name (Plaintiffs and Defendants):	[redacted]s Cheryl Hamlin, Maureen Coo
Venue:	Middlesex
Current status of claim:	Closed
Was the case resolved before the entry of a verdict?	Yes
What was the reason?	Settlement

If a payment was made, please indicate the following:

Amount allocated to you:	$1200000
Date of Payment:	1/25/2018

AMA Physician Profile

PREPARED FOR

New Mexico Medical Board, Santa Fe, NM

Name and Mailing Address

CHERYL LYNN HAMLIN
[redacted]
ARLINGTON, MA 02476-8019

Birth date [redacted]

Primary Office Address

MOUNT AUBURN HOSPITAL
DEPT OB
330 MOUNT AUBURN ST
CAMBRIDGE, MA 02138-5597
Phone (781) 983-5550

Physician's major professional activity HOSPITAL BASED FULL-TIME PHYSICIAN STAFF

Self-designated practice specialty OBSTETRICS & GYNECOLOGY (primary)
UNSPECIFIED (secondary)

Self-designated practice specialties (SDPS) listed on the AMA Physician Profile do not imply recognition or endorsement of any field of medical practice by the Association nor does it imply verification by a member board of the American Board of Medical Specialties (ABMS) or that the physician has been trained or has special competence to practice the SDPS.

AMA membership status NON MEMBER

All information from this point forward is provided by the primary source

Current and/or historical NPI information

National Provider Identifier (NPI)	Enumeration Date	Deactivation Date	Reactivation Date	Replacement Number	Last Reported Date
[redacted]	03/16/2006	NOT RPTD	NOT RPTD	NOT RPTD	04/08/2022

Current and/or historical medical school

UNIVERSITY OF ILLINOIS AT CHICAGO COLLEGE OF MEDICINE

Degree Awarded: YES
Degree Year: 1988

AMA
AMERICAN MEDICAL ASSOCIATION

Current and/or historical post graduate medical training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME)

Beginning with the 2010 cycle of the National GME Census, post-graduate training segments will include the name of the program attended in addition to the sponsoring institution. Program-level information prior to 2010 will not be available for reporting. Future training dates, as reported by the program, should be interpreted as "in progress" or "current" with the projected date of completion.

Beginning with the 2016/2017 cycle of the National GME Census post-graduate training segments will include a training type of specialty (residency) or subspecialty (fellowship). Training types for programs reported prior to 2016 will not include this designation.

Post-graduate training performed at accredited osteopathic institutions or in Canada are updated on the AMA Physician Masterfile only upon verification by the program. US licensing authorities accept graduate medical education from both entities as equivalent to training performed in a US program accredited by ACGME.

If a segment below is indicated as "being re-verified", it typically means that the physician is a current resident and the AMA is confirming with the residency program that the physician is still enrolled - this standard process occurs on an annual basis.

Sponsoring Institution: BOSTON CITY HOSPITAL
Sponsoring State: MASSACHUSETTS
Specialty: OBSTETRICS & GYNECOLOGY
Training Type:
Dates: 7/1988 - 6/1992 (Verified)

NATIONAL BOARD OF MEDICAL EXAMINERS (NBME) CERTIFICATION YEAR: MD: 1990

Specialty Board Certification

Specialty Board Certification(s) by one or more of the 24 boards recognized by the American Board of Medical Specialties (ABMS) and the American Medical Association (AMA) through the Liaison Committee on Specialty Boards, as reported by the ABMS:

The AMA Physician Profile has been designated by the ABMS as an Official ABMS Display Agent of Member Board Certification data. Therefore, the ABMS Board Certification information on the AMA Physician Profile is considered a designated equivalent source in regard to credentialing standards set forth by Joint Commission. The AMA is also an NCQA-approved source for verification of medical school, postgraduate medical training, ABMS Board certification, and Federal DEA registration.

Certifying board: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
Certificate: OBSTETRICS & GYNECOLOGY
Certificate type: GENERAL

Duration	Status	Effective Date	Expiration Date	Reverify Date	Occurrence	Last Reported	Participating in MOC
TIME LIMITED	Active	12/31/2021	12/31/2022		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2020	12/31/2021		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2019	12/31/2020		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2018	12/31/2019		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2017	12/31/2018		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2016	12/31/2017		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2015	12/31/2016		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2014	12/31/2015		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2013	12/31/2014		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/16/2012	12/31/2013		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2011	12/31/2012		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2010	12/31/2011		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2009	12/31/2010		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2008	12/31/2009		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2007	12/31/2009		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2006	12/31/2008		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2005	12/31/2007		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	12/31/2004	04/30/2007		RE-CERT	04/19/2022	Y
TIME LIMITED	Expired	11/17/1995	12/31/2005		INITIAL	04/19/2022	Y

For certification dates, a default value of "01" appears in the day or month field if data were not provided to AMA. Please contact the appropriate specialty board directly for this information.

Current and/or historical medical licensure

License Number	MD / DO	Locale	Date Granted	Expiration Date	Renewal Date	Status	License Type	Last Reported	Name on License
38877	MD	AL	01/01/2020	12/31/2022		ACT	UNL	01/20/2022	Cheryl Lynn Hamlin
25003	MD	MS	05/26/2017	06/30/2022	07/01/2021	ACT	UNL	02/02/2022	CHERYL L HAMLIN
74421	MD	MA	06/26/1991	06/15/2022		ACT	UNL	01/21/2022	Cheryl Lynn Hamlin

Abbreviation key: ACT = Active, DEN = Denied, INA = Inactive, LIM = Limited, NRT = Not reported, RES = Resident, TEM = Temporary, UNK = Unknown, UNL = Unlimited

Action Notifications

To date, there have been no actions reported to the AMA by any US state licensing agency.

To date, there have been no Medicare/Medicaid sanctions reported to the AMA by the Department of Health and Human Services.

To date, there have been no federal sanctions reported to the AMA by any branch of the US military, the Veteran's Administration or the US Department of Justice.

U.S. Drug Enforcement Administration (DEA)

DEA Number*	Business Activity†	Drug Schedule	Activity	Expiration Date	Payment Indicator	Last Reported	Address
[redacted]	C-0	[redacted]	Active	10/31/2022	Paid	04/01/2022	Mount Auburn Hospital 330 Mount Auburn St Cambridge, MA 02138-5597

** Only the last three characters of DEA numbers are displayed*

† The Business Activity code and subcode provide additional detail about the physician. For instance, Business Activity code-subcode combinations C-1, C-4, C-5, C-6, C-9, C-A, C-B, C-C, and C-D indicate the physician holds a DEA DATA waiver. Learn more about Business Activity code-subcode combinations.

Many states require their own controlled substances registration/license. Please check with your state licensing authority for requirement information as the AMA does not maintain this information.

ECFMG Certification

Applicant Number:

The Educational Commission for Foreign Medical Graduates (ECFMG) applicant identification number does not imply current ECFMG certification status. To verify ECFMG status, contact the ECFMG Certification Verification Service online at https://cvsonline2.ecfmg.org/

Profile Information

The content of the AMA Physician Profile is intended to assist with credentialing. An organization's appropriate use of the data contained in the AMA Physician Masterfile meets selected primary source verification requirements of the Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC) and the American Accreditation Health Care Commission(AAHCC)/Utilization Review Accreditation Commission (URAC). The AMA Physician Masterfile is also an NCQA-approved source for verification of medical school, post-graduate medical training, ABMS Board Certification and federal DEA registration.

If any of the data in this Profile is believed to be incorrect, please log in to your account on our profiles website, go to the profile manager tab, find the provider for whom you think we have inaccurate information and click on the "Report" button in the "Report a Discrepancy" column. Enter any of the information that you feel needs to be researched. The AMA will contact the primary source of the data to determine which data is correct. We will notify you of the outcome of our research. If any changes are made to the profile we will update the link in profile manager for this provider so that you can access the new, updated information.

If you have any questions or need additional information about the AMA Physician Profile Service, please call (800) 665-2882.

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:4/22/2022

PRACTITIONER INFORMATION

Name: Hamlin, Cheryl Lynn
DOB: [redacted]
Medical School: University of Illinois College of Medicine
Chicago, Illinois, UNITED STATES
Year of Grad: 1988
Degree Type: MD
NPI: [redacted]

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

NATIONAL PROVIDER IDENTIFIER (NPI)

NPI	NPI Type	Deactivation Date	Reactivation Date	Last Reported
[redacted]	Individual			06/04/2018

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated
ALABAMA	00038877	01/01/2020	12/31/2022	04/21/2022
		FSMB License Status: Active		
MASSACHUSETTS	74421	06/26/1991	06/15/2022	04/05/2022
		FSMB License Status: Active		
MISSISSIPPI	25003	05/26/2017	06/30/2022	04/01/2022
		FSMB License Status: N/A		

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for: New Mexico Medical Board As of Date:4/22/2022

Practitioner Name: Hamlin, Cheryl Lynn

ACTIVE US DRUG ENFORCEMENT ADMINISTRATION (DEA)

DEA Number	Schedule	Address	Expiration Date	Last Reported
FH9911808	22N 33N 4 5	BIRMINGHAM,AL 35203	10/31/2023	01/05/2022
BH3205285	22N 33N 4 5	CAMBRIDGE,MA 02138	10/31/2022	01/05/2022
FH8216877	22N 33N 4 5	JACKSON,MS 39216	10/31/2024	01/05/2022

PDC PHYSICIAN DATA CENTER

fsmb

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:4/22/2022
Practitioner Name:	Hamlin, Cheryl Lynn	

ABMS® CERTIFICATION HISTORY

Certifying Board:	American Board of Obstetrics and Gynecology
Certificate:	Obstetrics and Gynecology
Certification Type:	General
Certification Status:	Certified
Participating in MOC:	Yes

Status	Duration	Effective Date	Expiration Date	Reverification Date	Occurrence	Last Reported
Active	Time Limited	12/31/2021	12/31/2022		Recertification	03/31/2022
Expired	Time Limited	12/31/2020	12/31/2021		Recertification	03/31/2022
Expired	Time Limited	12/31/2019	12/31/2020		Recertification	03/31/2022
Expired	Time Limited	12/31/2018	12/31/2019		Recertification	03/31/2022
Expired	Time Limited	12/31/2017	12/31/2018		Recertification	03/31/2022
Expired	Time Limited	12/31/2016	12/31/2017		Recertification	03/31/2022
Expired	Time Limited	12/31/2015	12/31/2016		Recertification	03/31/2022
Expired	Time Limited	12/31/2014	12/31/2015		Recertification	03/31/2022
Expired	Time Limited	12/31/2013	12/31/2014		Recertification	03/31/2022
Expired	Time Limited	12/16/2012	12/31/2013		Recertification	03/31/2022
Expired	Time Limited	12/31/2011	12/31/2012		Recertification	03/31/2022
Expired	Time Limited	12/31/2010	12/31/2011		Recertification	03/31/2022
Expired	Time Limited	12/31/2009	12/31/2010		Recertification	03/31/2022
Expired	Time Limited	12/31/2008	12/31/2009		Recertification	03/31/2022
Expired	Time Limited	12/31/2007	12/31/2009		Recertification	03/31/2022
Expired	Time Limited	12/31/2006	12/31/2008		Recertification	03/31/2022
Expired	Time Limited	12/31/2005	12/31/2007		Recertification	03/31/2022
Expired	Time Limited	12/31/2004	04/30/2007		Recertification	03/31/2022
Expired	Time Limited	11/17/1995	12/31/2005		Initial	03/31/2022

PRACTITIONER PROFILE

Prepared for:	New Mexico Medical Board	As of Date:4/22/2022
Practitioner Name:	Hamlin, Cheryl Lynn	

AOA® CERTIFICATION HISTORY

No AOA Certifications found.

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: Cheryl Hamlin Date of Birth [redacted]
Applicant' Signature: [redacted] Date: 4/7/22
Address: [redacted] City Arlington State MA

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as Colleague
from 2008 (Month/Year) to present (Month/Year) at Mount Auburn Hospital (Location)

2. Please evaluate:

	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation: (please indicate with a check mark)
1. Recommend highly and without reservation ✓
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.
Cheryl is an outstanding clinician, teacher and team member. Your organization is lucky to have her!

5. The above report is based on: (please indicate with check mark)
1. Close personal observation ✓
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): Leslie MacDonald Title: MD Vice-Chair Dept of OB&GYN Phone: 617-503-1000
Signature: LMacDonald Date: 4/14/2022

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

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MAY 03 2022
NM MEDICAL BOARD

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: CHERYL HAMLIN Date of Birth [redacted]

Applicant's Signature: [redacted] Date: 4/7/22

Address: [redacted] City Arlington State MA

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as [redacted] - Colleague in Ob-Gyn Dept

from March 2009 (Month/Year) to current (Month/Year) at Mt Auburn Hospital, Cambridge, MA (Location)

2. Please evaluate:

	(Please indicate with check mark)			
	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation: (please indicate with a check mark)

1. Recommend highly and without reservation ✓
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Very thoughtful clinician. Very capable in Obstetrics with wide skill set.

5. The above report is based on: (please indicate with check mark)

1. Close personal observation ✓
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): Malcolm Mackenzie, MD Title: Attending Ob-Gyn Phone: 603-762-2200

Signature: [signature] Date: 4-25-22

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

PROFESSIONAL RECOMMENDATION

The New Mexico Medical Board requires the completion of this Professional Recommendation by a physician or a Chief of Staff or a Department Chief with whom I have worked and who has personal knowledge of my character and competence to practice medicine. This form is required as part of my application for licensure. ***All*** elements in the section below ***must*** be completed. The lower half of the form may be used for narrative comment. This is my authorization to release all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant's Name: Cheryl Hamlin Date of Birth [redacted]

Applicant' Signature: Date: 5/10/22

Address: [redacted] City Arlington State MA

ALL ELEMENTS IN THIS SECTION MUST BE COMPLETED BY THE RECOMMENDING PHYSICIAN
The information on this form is NOT a public document.

1. Date and type of service: This individual served with me as staff physician

from _____ (Month/Year) to _____ (Month/Year) at Women's Health Services, 111 Harvard St. Brookline, MA 02445 (Location)

2. Please evaluate:

	(Please indicate with check mark)			
	Poor	Fair	Good	Superior
Professional knowledge				✓
Clinical judgment				✓
Relationship with patients				✓
Ethical/professional conduct				✓
Ability to communicate				✓
Clinical skills				✓

3. Recommendation: (please indicate with a check mark)

1. Recommend highly and without reservation ✓
2. Recommend as qualified and competent
3. Recommend with some reservation (explain)
4. Concerns (explain)

4. Of particular value in evaluating the candidate is information regarding any notable strengths and weaknesses (including personal demeanor). We would appreciate your comments.

Strengths: team player, caring, skilled surgeon, compassionate

5. The above report is based on. (please indicate with check mark)

1. Close personal observation ✓
2. General impression
3. A composite of evaluations
4. Other

Name (Please Print): LAURENT C. DELL-BOVI, MD Title: Medical Director Phone: 617 277-0099

Signature: Laurent Dell-Bovi Date: 5/10/22

Medical Director
Women's Health Services

State of Alabama

Medical Licensure Commission

Craig H. Christopher, M.D., Chairman/Executive Officer
Karen Silas, Director of Operations

04/13/2022

New Mexico Medical Board
2055 South Pacheco Street
Building 400
Santa Fe, NM 87505-0503

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our Records)
Cheryl Lynn Hamlin

Date of Birth: [redacted]
License Number: **MD.38877**
Current Status: **Active**
Date Issued: **01/01/2020**
Basis of License: **NBME/MA**
Expiration Date: **12/31/2022**
Medical School: **University of Illinois College of Medicine - Rockford**
Location: **Rockford**
Date From/To: **08/84-06/88**

Disciplinary Actions:

[X] No

[ ] Yes, visit Public Actions at www.albme.gov for documents.

Signature: Craig H Christopher M.D.
Craig H. Christopher, M.D. Chairman
Medical Licensure Commission of Alabama

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabama. Verification information can also be obtained by accessing our website at http://www.albme.gov.

4/11/22

TELEPHONE: (601) 987-3079

FAX: (601) 987-4159

MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE

VERIFICATION OF MEDICAL LICENSURE

April 19, 2022

This is to certify that the records of the Mississippi State Board of Medical Licensure indicate the following information:

Physician Name: **CHERYL L HAMLIN** Degree: **M.D.**

Date of Birth: [redacted]

Primary Practice Location: **MOUNT AUBURN HOSPITAL**
330 MOUNT AUBURN ST
CAMBRIDGE, MA 02138

MD/DO School: **UNIVERSITY OF ILLINOIS PEOR** Year of Graduation: **1998**

Specialty: **OBSTETRICS AND GYNECOLOGY (Not Primary Source Verified)**

License Number: **25003**
Issue Date: **May 26, 2017**
Expiration Date: **June 30, 2022**
Public Record: **NO**

Reinstated Date:
Date of Expiration Prior to Reinstatement:

This license information was last updated on: 04/19/2022

If public record is indicated, submit a request for records to the following email address: mboard@msbml.ms.gov.

Sincerely,

Kenneth Cleveland, MD
Executive Director

4/4/22

The Commonwealth of Massachusetts
Board of Registration in Medicine

178 Albion Street, Suite 330
Wakefield, MA 01880
(781) 876-8200

www.mass.gov/massmedboard

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

5/27/2022

To Whom It May Concern:

This certifies that Cheryl Lynn Hamlin, M.D., a 1988 graduate of University of Illinois College of Medicine, has been duly registered by this board as provided by the laws of the Commonwealth.

Certificate Number 74421 was issued to Dr. Hamlin on 06/26/1991. The license status is: Active. The expiration date is 6/15/2024.

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

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
APR 26 2022
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Cheryl Hamlin
[redacted]
Address
Arlington, MA 02476
City/State/Zip

Applicant Signature
07/2008 to present
*Dates of [redacted] provided)
Telephone [redacted]

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Edwin HUANG MD
Type or Print Name of person completing this form
Chair of Obstetrics & Gynecology
Title
Mount Auburn Hospital
Name of Institution
330 Mount Auburn Street
Address
Cambridge, MA 02138
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___ No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Please affix hospital or notary seal here

Edwin Huang — Printed name of person completing this form
Signature
4/19/22 — Date

No notary available
Signature of Notary (if applicable)
Date

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

RECEIVED
APR 29 2022
NM MEDICAL BOARD

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Applicant Name: Cheryl Hamlin [redacted]
Address: arlington, MA 02476
City/State/Zip

Applicant Signature
01/2020 to present
*Dates of Privilege/Employment mm/yy to mm/yy (must be provided)
[redacted]
Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

JANET LEFKOWITZ
Type or Print Name of person completing this form
DIRECTOR, REPRODUCTIVE HEALTH SERVICES
Title
PLANNED PARENTHOOD SOUTHEAST
Name of Institution
204 PEACHTREE ST NE - STE 4000
Address
ATLANTA, GA 30303
City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ✓ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ✓No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ✓No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ✓No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓Yes ___No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

ELIZABETH JEAN NICKERSON
NOTARY PUBLIC
STATE OF RHODE ISLAND
Please affix hospital or notary seal here

JANET LEFKOWITZ — 4/22/22
Printed name of person completing this form — Signature — Date

4/22/22
Signature of Notary (if applicable) — Date

My commission expires: 7/15/22

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above

4/11/22

RECEIVED
MAY 03 2022
NM MEDICAL BOARD

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Appl Cheryl Hamlin [redacted]

Address

City/State/Zip Arlington, MA 02474

Applicant Signature

*Dates of Privilege/Employment, month to month/yr (must be provided) 09/2017 to present [redacted]

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Shannon Brewer
Type or Print Name of person completing this form

EXECUTIVE Director
Title

JACKSON Women's Health, Org.
Name of Institution

2903 N. STATE ST
Address

JACKSON, MS. 39216
City / State / Zip

1. This evaluation is based on: ___Observation of applicant ___Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___Yes ✓No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___Yes ✓No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___Yes ✓No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓Yes ___No

If not, please provide correct dates: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Shannon Brewer — Printed name of person completing this form
SBrew — Signature
4/29/2022 — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable) — Date

My commission expires: _____

NO NOTARY AVAILABLE

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above

4/11/22

RECEIVED
JUN 01 2022
NM MEDICAL BOARD

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, 2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.

Applicant Name: Cheryl Hamlin [redacted]

Address: [redacted]

City/State/Zip: Arlington, MA 02476

Applicant Signature: [signature]

*Dates: 01/2017 to present [redacted] provided)

Telephone Number:

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are *NOT* accepted in lieu of this form.

Type or Print Name of person completing this form: LAURENT C. DELLI-BONI, MD

Title: Medical Director

Name of Institution: Women's Health Services

Address: 111 Harvard St

City · State · Zip: Brookline, MA 02446

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ___ Yes ✓ No

***If not, please provide correct dates**: Beginning _____ (Month/Year) Ending _____ (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Laurent Delli-Boni — Laurent Delli-Boni — 5/10/22
Printed name of person completing this form — Signature — Date

Please affix hospital or notary seal here

Signature of Notary (if applicable): NO HOSPITAL OR NOTARY SEAL AVAILABLE — Date

My commission expires

Please note on this form if there is no hospital or notary seal available.

Please return this form directly to the address above
Thank you for your cooperation

4/11/22

New Mexico Medical Board
2055 S. Pacheco St.
Building 400
Santa Fe, NM 87505
(505) 476-7220

WORK EXPERIENCE VERIFICATION

I am applying for a medical license in the State of New Mexico. The New Mexico Medical Board requires this form to be completed by the Chief of Staff or facility's administrative staff. I hereby authorize release of all information in your files, favorable or otherwise, DIRECTLY to the NMMB, **2055 S. Pacheco St., Bldg. 400, Santa Fe, NM 87505.**

Applicant Cheryl Hamlin [redacted]

Address

City/State/Zip Arlington, MA 02476

Applicant Signature

*Dates of Privi[redacted] provided) 01/2017 to present

Telephone Number

The section below should be completed by the chief of staff or facility's administrative staff.
Letters of Recommendation are ***NOT*** accepted in lieu of this form.

Type or Print Name of person completing this form: Nicole Marie Giglio

Title: Certified Registered Nurse Anesthetist (CRNA)

Name of Institution: Women's Health Service

Address: 111 Harvard Street, Brookline MA 02446

City / State / Zip

1. This evaluation is based on: ✓ Observation of applicant ___ Review of personnel file
2. In your estimation, is there any reason why this applicant should not be licensed to practice? ___ Yes ✓ No
3. To your knowledge, is there any mental or physical reason why this applicant should not be licensed? ___ Yes ✓ No
4. To your knowledge, is there any derogatory/disciplinary information regarding this applicant? ___ Yes ✓ No
5. Are the dates of privilege/employment provided by the applicant on this form accurate?* ✓ Yes ___ No

***If not, please provide correct dates**: Beginning 01/2017 (Month/Year) Ending present (Month/Year)

If you answered "YES" to questions 2, 3, and/or 4, please provide a written explanation and/or any supporting documentation that may be relevant.

Nicole Marie Giglio — Printed name of person completing this form

[signature] — Signature

6/4/2022 — Date

No Notary — Signature of Notary (if applicable)

6/4/2022 — Date

Please affix hospital or notary seal here

My commission expires: _____

Please note on this form if there is no hospital or notary seal available.

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