Please Note: If you have questions concerning the licensing process, contact the residency program coordinator or the residency training office at the Massachusetts hospital where your training will be undertaken.

Limited License Fee: The fee for a limited license is $100.00. Please attach a personal check or money order payable to the Commonwealth of Massachusetts. Applications will not be processed without the fee.

Limited Licensure: Limited licenses are issued to physicians enrolled in post-graduate medical education programs in teaching hospitals in the Commonwealth of Massachusetts. All such training must be done in ACGME accredited programs, or in a subspecialty clinical training or fellowship program in a training facility that has an approved program in the parent specialty. This information must be documented by the training program in Section C of the Change of Program Limited License Application form.

A physician who holds or who has ever held a full Massachusetts license is not eligible for a limited license. You may practice medicine only in the training program with this application. With a limited license, you are not allowed to “moonlight” under any circumstances.

Processing time for a Change of Program Application is approximately 4 to 6 weeks after the application has been received by the Board. Some applications may necessitate a longer processing time. The Board will notify the training program upon approval of your Change of Program. You may not engage in any direct or indirect patient care until your limited license has been approved.

Change of Program Application: The Change of Program form is to be used when the following occurs:

- Change of Specialty (example: General Surgery to Neurosurgery);
- Change of Specialty to Subspecialty (example: Anesthesia Residency to Cardiac Anesthesia Specialty or Anesthesia Residency to Pediatric Anesthesia Fellowship);
- Change of Hospital (example: Massachusetts General Hospital to Boston Medical Center); or
- Change of Program Director except when there is a personnel change of director within a specified program; under these circumstances, use a Renewal Form.

Sections A and C must be completed by the applicant and any other forms which may apply. The Change of Program Application must be forwarded to the training program for completion of Section B.

Question #5 B: If you left a training program only because it was a prerequisite for the program you are entering, you may answer “yes” to this question. If your answer is “no” please provide an explanation and you must follow all of the instructions listed under Question #5-C.

Evaluation Form: The Evaluation Form must be completed by your current program director if you answered “no” to questions 5-B or 5-C or if you answered “yes” to questions 16-35 and included with your change of program application. Please inform the program director that the completed Evaluation Form must be placed in a sealed envelope. If the seal on the envelope is broken, then the process must be repeated.

License Verification: If you have become fully licensed anywhere in the United States, Puerto Rico, or Canada since your initial limited licensure in Massachusetts, you must authorize verification of your licensure to the Board. Please sign the attached form, Verification of Licensure, and send it to the appropriate state.
medical licensing agency(ies). The state license verification(s) from each state must be sent to the Board with your change of program application. **Do not open the state license verification(s) and inform the members of your household not to open the envelope(s).** If the seal on the state license verification envelope is broken, it will be returned to you and you will be required to repeat the process.

**Name Change:** If you have had a name change, you must submit a notarized copy of your marriage certificate or a notarized copy of the court order changing your name.

See attached instructions for completion of Questions 6-25 and the Limited License Supplement.

**SECTION A**

**Mailing address:** Provide a mailing address and telephone number at which we can reach you. You must immediately notify the Board of any change in this information.

**Name of Massachusetts training hospital:** This is the name of the training program at which you will be practicing with your Limited License.

**SECTION B MUST BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL AT THE FACILITY WHERE THE APPLICANT WILL BE TRAINING.**

The following instructions will help you answer Questions 6-25. If you answer “yes” to any of these questions, you must also fill out the supplemental pages. Read these instructions and the supplemental pages carefully. Your application may be delayed if you fail to provide all the information requested.

This portion of the application is not a public record, and is held as confidential information unless you expressly authorize the Board to release it to a particular party. Under the law, the Board may also share this information with legally designated agencies, such as other state licensing boards and law enforcement agencies. Designated agencies are required to maintain the confidentiality of this information consistent with the law.

6-A. **Postgraduate-training program leaves and withdrawals:** You must report all leaves of absence, withdrawals or if you had to repeat a postgraduate training program, regardless of the reason. Provide an explanation on the supplemental pages.

6-B. **Probation in any postgraduate training program:** You must report a probation in any postgraduate training program, regardless of the reason for the probation.

8. **Medical license application withdrawal or denial of medical license:** You should answer “yes” if you withdrew your application after learning that your license application probably would not be approved or would be approved only with conditions or restrictions. You do not need to answer “yes” if you withdrew your application solely because of a decision to relocate that was entirely unrelated to anticipated rejection of your application, or if you let your license lapse because you no longer practice medicine in that jurisdiction.

9. **Voluntary surrender of license:** You must report any surrender of a license to a licensing board or other governmental agency. You do not need to answer “yes” to this question if you let your license lapse because you no longer practice medicine in that jurisdiction.

10 and 11. **Disciplinary Action:** A confidentiality agreement does not absolve you of your requirement to answer Questions 10 and 11. If you answer “Yes” you must also complete the supplement.
For the purpose of answering Question 20 and 21, the terms listed below have the following meanings:

An “investigation” is any inquiry conducted by a private or governmental authority concerning you.

This question includes, but is not limited to, investigations, reviews, and inquiries conducted by: hospitals, clinics, nursing homes, health insurers, medical malpractice insurers, professional associations, federal agencies, and state agencies. This question includes investigations, reviews, and inquiries conducted by the Massachusetts Board of Registration in Medicine and its sub-Committees, including the Data Repository Committee and the Complaint Committee.

You do not need to report investigations of an entire facility or department. For example, an annual departmental review of complication rates is not a reportable investigation within the meaning of this question because your activities have not been singled out for review.

A “governmental authority” refers to any federal, state, county, or municipal governmental entity, including but not limited to: any medical licensing board (including Massachusetts), any agency regulating health care quality, any medical assistance authority, any regulatory authority investigating insurance fraud, and any agency that regulates the possession, dispensing, and prescribing of any controlled substances.

A “health care facility” refers to any hospital (including federal, state, county, and municipal hospitals), clinic, prison infirmary, home for unwed mothers, nursing home, or health maintenance organization. For the purpose of this question, a health care facility includes a post-graduate training program.

“Group practice” refers to any association of healthcare professionals organized for the delivery of patient care of which you are a member or partner or by which you are employed or with which you have a contract for professional services, including a partnership or limited liability partnership, limited liability company, professional corporation, or other professional business organization.

“Disciplinary action,” as defined in the Board’s regulations, is an action which adversely affects a licensee. The action can be formal or informal, oral or written, and voluntary or involuntary.

Disciplinary actions that are always reportable to the Board include, but are not limited to, the following or their substantial equivalents: revocation of a right or privilege, suspension of a right or privilege, censure, written reprimand or admonition, fines, and required performance of public service.

Disciplinary actions that are sometimes reportable to the Board include, but are not limited to, the following or their substantial equivalents: restriction of a right or privilege, non-renewal of a right or privilege, denial of a right or privilege, resignation, leave of absence, withdrawal of an application, and termination or non-renewal of a contract. These actions are reportable to the Board if they arose, directly or indirectly, from the licensee’s competence to practice medicine, or from a complaint or allegation regarding any violation of law, regulation, or bylaw.

For example, non-renewal of a medical license in another state based on the licensee’s cessation of practice there is not a disciplinary action.

For example, a leave of absence taken for family reasons or for illness is not a disciplinary action.

For example, termination or non-renewal of an employment contract due to relocation is not a disciplinary action.
A course of education, training, counseling or monitoring is reportable to the Board as a disciplinary action only if it arose out of the filing of a complaint or other formal charges reflecting on the licensee’s competence to practice.

12, 13, 14 and 15. Medical staff membership, status and privileges: You must answer these questions about your medical staff status at any health care facility at which you have ever had membership or privileges. You do not need to include information about your tenure at health care facilities as a medical student or resident.

16. Criminal proceedings: Being “charged with a criminal offense” includes being arrested, arraigned or indicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. You must also report: convictions for felonies and misdemeanors; nolo contendere pleas; matters where sufficient facts of guilt were found; matters that were continued without a finding; and any other plea bargain. A medical malpractice claim is a civil, not a criminal, matter. A charge of Driving Under the Influence is not a “minor traffic offense” and should be reported.

17. Controlled substances privileges: You do not need to answer "yes" if you permitted your state and/or federal license(s) to expire solely because you decided to relocate and your decision to relocate was entirely unrelated to allegations of wrongful or otherwise irregular prescription practices.

18. Malpractice claims: You must report all malpractice claims, whether or not they resulted in lawsuits and whether they are pending or have been resolved. You must answer “yes” even if you were named in a case or claim and subsequently dropped from it or the case or claim was dismissed with no finding against you or payment made on your behalf. You must report all cases or claims filed or heard in any state.

19. Non-malpractice lawsuits: You must report certain lawsuits filed against you even if they do not allege malpractice. Examples include, but are not limited to lawsuits filed under consumer protection, antitrust, civil rights, fraud, or intentional tort (e.g. libel, interference with contractual relations) laws. You must report only those suits relating to your competency to practice medicine or your professional conduct in the practice of medicine.

20 through 25. Medical condition: “Medical condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, hearing and memory impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cerebrovascular disease, cognitive disorders, cancer, heart disease, diabetes, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

“Ability to practice medicine” is to be construed to include all of the following:
1. The cognitive capacity to make appropriate clinical diagnoses, exercise reasoned medical judgments and learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

“Currently” does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one’s functioning as a licensee, or within the past two years.

22. Use of Chemical Substances: “Chemical substances” is to be construed to include alcohol, drugs or medications, including those drugs or medications (controlled substances) taken pursuant to a valid prescription for legitimate medical purposes and in accordance with this direction, as well as those used illegally. Illegal use of controlled substances includes use of substances obtained illegally (for example,
heroin or cocaine) as well as the use of substances in an illegal manner (for example, use of prescription drugs which are obtained without a valid prescription or taken not in accordance with the directions of a licensed health care practitioner).

24. **Illegal use of drugs:** See definitions above.

You have a right to elect not to answer the above question if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of the Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment privilege, you must do so in writing. Your limited license application will be processed if you claim the privilege.

25. **Voluntary modification of scope of practice:** Describe any voluntary modification of or limitation to your scope of practice not covered by Questions 30 and 31, and the reasons for it.

**A Note to the Physician who is Chemically Dependent**

If you are chemically dependent, the Board encourages you to seek assistance voluntarily. When the Board receives notice of impairment or dependency, its policy is to protect the public but also to ensure rehabilitation through the physician's participation in approved treatment programs and supervised, structured aftercare. The Board's Chemically Dependent Physician Policy relies on cooperation between the Board and groups like the Massachusetts Medical Society's Physician Health Services to ensure successful rehabilitation.

**PLEASE NOTE:** If you answered “yes” to any of Questions 6-25, you must also fill out the supplemental pages.

Revised: 12.18.2013
CHECKLIST FOR CHANGE OF PROGRAM APPLICATION

A change of program application is for physicians who are changing a specialty, subspecialty or training program.

HAVE YOU

☐ Downloaded all of the pages of the change of program application form?

☐ Read the instructions, answered every question, signed the application and Authorization for Release of Information form and enclosed a check for $100.00 made payable to the Commonwealth of Massachusetts?

☐ Completed the supplemental pages if you answered "yes" to any questions?

☐ Included license verifications, in sealed envelopes, from every state where you were issued a full license since your last renewal and attached them to your limited license application?

☐ Included a completed Evaluation form from your current program director (the training program that you are leaving)? Please instruct the program director to return the completed Evaluation form to you in a sealed envelope and attach it to your change of program application.

IF THE SEALS ON ANY ENVELOPES ARE OPENED, THE INFORMATION WILL NOT BE ACCEPTED BY THE BOARD. PLEASE CONTACT THE PROGRAM COORDINATOR AT YOUR TRAINING PROGRAM IF YOU HAVE ANY QUESTIONS.
CHANGE OF PROGRAM APPLICATION

IMPORTANT: Please read accompanying instructions before completing the application and print legibly. Sections A and C must be completed by the applicant. Attach check for $100.00 made payable to Commonwealth of Massachusetts.

SECTION A: To be completed by applicant.

1. Name: (Last) ___________________________ (First) ___________________ (MI) __________

2. Mailing Address: ___________________________ Telephone Number: __________________
   City: ___________________________ State: __________ Zip: __________

3. Name of Medical School: ___________________________ Year Graduated: __________

4. Name of Training Program: ____________________________________________________

5. Current Limited License Number: ___________________________

5-A Previous Training Programs: List previous license numbers, training institutions and programs

<table>
<thead>
<tr>
<th>License #</th>
<th>Training Program Name</th>
<th>City and State</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other State Licenses: List states (abbreviations) where you are currently licensed to practice medicine (include residency training licenses). Indicate whether full license, residency or limited license.

_____ □ (Full) _____ □ (Full) _____ □ (Full) _____ □ (Limited) _____ □ (Limited)

5-B. Was your previous training a prerequisite for entering this program? YES □ NO □

5-C. Did you complete your previous training program(s)? YES □ NO □

If you answered “no” to 5-B or 5-C, attach an explanation. The program director must provide a letter certifying the circumstances under which you left the training program and complete the enclosed evaluation form. The letter and evaluation form must be placed in an envelope by the program director and sealed and signed across the seal. Please note that if the seal on the envelope is broken the documents will not be accepted.

THIS SECTION MUST BE COMPLETED BY THE CURRENT PROGRAM DIRECTOR

Is the above named physician in good standing in the Residency/Fellowship program? YES □ NO □

Has the physician been subject to any past or pending disciplinary action in this program? YES □ NO □

Type or Print Name and Title ___________________________ Date: _____ / _____ / _____

Signature of Program Director ___________________________ Telephone: __________
SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL AT THE FACILITY WHERE THE APPLICANT WILL BE TRAINING.

This certifies that ___________________________________________ has been appointed to the
position of □ Intern □ Resident □ Fellow
in the specialty of ___________________________________________ as a PGY ________________
Department:_________________________________________ Subspecialty:_____________
at __________________________________________________________
(Name of Healthcare Facility)

beginning ______/______/_____. to anticipated completion of training: ______/_____/_____.
Month Day Year
Month Day Year

YES □ NO □

Is the training program listed above ACGME accredited?
If no is there an approved ACGME program in applicant’s specialty?

Designated Official’s Signature: ____________________________ Date: ______/_____/_______
Type or Print Name: ____________________________________________ Telephone _______________
Official Title: ____________________________________________

SECTION C ON PAGE 3 TO BE COMPLETED BY APPLICANT
SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?  YES   NO

6-B. Have you, for any reason, been placed on probation in any postgraduate training program?  YES   NO

7. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?  YES   NO

8. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?  YES   NO

9. Have you voluntarily surrendered a license to practice medicine or any healing art?  YES   NO

10. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).  YES   NO

11. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).  YES   NO

12. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?  YES   NO

13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?  YES   NO

14. Have you voluntarily relinquished medical staff membership?  YES   NO

15. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?  YES   NO

16. Have you been charged with any criminal offense, other than a minor traffic offense?  YES   NO

17. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?  YES   NO

18. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?  YES   NO

19. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?  YES   NO

(Continued on page 3)
CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering “yes” to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, “currently” does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one’s functioning as a licensee, or within the past two years.

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEW

YES  NO

20. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician? □  □

21. Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician? □  □

22. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired? □  □

23. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? □  □

24. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs? □  □

25. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? □  □

If your responses to Questions 6-25 change while your application is pending, you must notify the Board of the new information immediately.
CERTIFICATIONS

I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

I will read the Board’s regulations, 243 CMR 1.00 through 3.00.

Under the penalties of perjury, I declare that I have examined this change of program application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete.

Signature:___________________________________ Date:___________________

Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to “moonlight” under any circumstances.

Revised: 12.18.2013
QUESTIONS #6-A, 6-B & 7 – Postgraduate training program and examinations

Attach additional pages with same format where necessary.

Name of institution: ____________________________________________ Date of action: ___/___/____
Address: ____________________________________________ City: ________________________
State: ___________________ Zip: ___________ Dates of attendance: From: ___/___/____ To: ___/___/____
Description of events: ____________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________

You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any probation, termination, leave of absence, withdrawal, failure to complete or requirement to repeat a postgraduate training program directly to the Board.

QUESTIONS #8 & 9 – License application withdrawal, denial or license surrender

Attach additional pages with same format where necessary.

Describe circumstances under which license application was withdrawn or denied, or license was voluntarily surrendered.
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
State: ____________________________ Year: ___/___/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding the withdrawal, denial or voluntary surrender directly to the Board. Such documentation must specify the reason(s) for denial or withdrawal of your license application or voluntary surrender of your license application.

QUESTIONS #10 & 11 – Disciplinary actions

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action: ____________________________ Date: ___/___/____
Description: _______________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.

Signature: ____________________________ Date: ___/___/____
PRINT NAME: ___________________________________________________

QUESTIONS #12, 13, 14 & 15 – Medical staff membership, status and/or privileges

Attach additional pages with same format where necessary. Describe circumstances leading to change in medical staff membership, status and privileges:

Name of facility: ____________________________________________ Date of action: ___/___/____
Address: __________________________________ City: __________________ State: ________ Zip: ______
Description: _____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 12, 13, 14 and 15 directly to the Board.

QUESTION #16 – Criminal proceedings

Attach additional pages with same format if more than one charge and where otherwise necessary.

Court: __________________________________ Charge: __________________ Date: ____/____/____
Please attach a detailed account of circumstances leading up to criminal proceedings.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Status: __________________________________
You must arrange for your lawyer or the court officer to submit copies of the police report, indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant directly to the Board.

QUESTION #17 – Controlled substances privileges

Attach additional pages with same format where necessary.

Type of restriction: ____________________________________ Date: ___/___/____
Circumstances of restriction: __________________________________
____________________________________________________________________________________
____________________________________________________________________________________
You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact and correspondence related to any affirmative response directly to the Board.

Signature: ____________________________________________ Date: ____/____/____
QUESTIONS #18 & 19 – Malpractice claims and other lawsuits
You must provide the following information on this form for each instance of alleged malpractice. You may photocopy this form and attach additional copies, if necessary. You must also complete the back of this form. Please print legibly.

Claimant’s name: __________________________________________________________ Date of incident: ___/____/____
Insurer’s name:________________________________________Insurer’s address: _________________________________

Description of alleged basis (es) of claim (allegations only: this does not constitute an admission of fault or liability). (See Basis for Allegation on page 7.)

Allegation ___________________ Allegation ___________________ Allegation ___________________

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient’s condition at point of your involvement:

2. Patient’s condition at end of treatment:

3. The nature and extent of your involvement with the patient:

4. Your degree of responsibility for the course of treatment leading to the claim:

5. If incident resulted in patient’s death, indicate cause of death according to autopsy or patient chart:

Incident location (check one):

□ 01 Emergency Room  □ 02 Labor/Delivery  □ 03 Laboratory/X-ray/Testing  □ 04 Operating Room
□ 05 Outpatient  □ 06 Patient Room  □ 07 Hospital-Other  □ 08 Hospital-Unknown
□ 09 HMO  □ 10 Clinic  □ 11 Nursing Home  □ 12 Physician’s Office
□ 13 Walk-in Center  □ 14 Other  □ 15 Unknown

Your role (check one):

□ 01 Anesthesiologist  □ 02 Primary Care Physician  □ 03 Referring Physician  □ 04 Attending Physician
□ 05 Consultant Specialist  □ 06 Surgeon  □ 07 Fellow  □ 08 PGY 7
□ 09 PGY 6  □ 10 PGY 5  □ 11 PGY 4  □ 12 PGY 3
□ 13 PGY 2  □ 14 PGY 1  □ 22 Acupuncturist  □ 26 On-call Physician
□ 27 Worker’s Comp Evaluator  □ 28 Court Psychiatrist  □ 24 Group Practitioner/Partner  □ 99 Unknown

(continued on next page)
QUESTION #18 & 19 - Malpractice claims & other lawsuits, continued…

Legal representative’s name: ____________________________________________________________
Address: ______________________________________________________________ Telephone: ___________________
City: ___________________________________ State: ______________________________ Zip: _____________

Current status of claim:  □ Closed □ Pending

Was the case resolved before the entry of a verdict?  □ Yes □ No

What was the decision?  □ Dismissed before trial □ Plaintiff Verdict □ Defense Verdict

Decision determined by:  □ Judge □ Jury

If a payment was made: Amount allocated to you: $___________ Payment Date:_____/_____/_____

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

Signature: ____________________________ Date: ____/____/____
CONFIDENTIAL MEDICAL INFORMATION

QUESTION #20 & 21 – Medical condition

If you answered “yes” to Questions #20 or 21, please explain the specifics of your condition and any related treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than three (3) months prior to the date of your application. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

QUESTION #22 – Use of chemical substances

If you have obtained medical treatment related to your use of chemical substances, explain the specifics of your treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of chemical substances on your current practice, including participation in any supervised rehabilitation program or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than thirty (30) days prior to the date of your application. You must also arrange for the appropriate institutions to submit all discharge summaries regarding any alcohol or drug dependency directly to the Board. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signature: _____________________________ Date: _____/_____/______
QUESTION #23 – Refusal to take screening test

If you answered “yes” to Question #23, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

QUESTION #24 – Illegal use or misuse of drugs

List chemical substances:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Describe frequency of usage:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please note that additional information may be requested by the Board.

QUESTION #25 – Voluntary modification of scope of practice

Describe circumstances leading to modification of practice:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Describe modification of practice:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Dates: From: _____/____/_____ To: _____/____/_____

Please note that additional information may be requested by the Board.

Signature: __________________________________________ Date: _____/____/_____
BASIS FOR ALLEGATION

ABUSE OF PATIENTS, EMPLOYEES/PEERS
Abuse of Employee(3)/Peer(s) - Physical
Abuse of Patient(s) - Physical
Sexual misconduct
Sexual misconduct - Verbal

ADMINISTRATIVE PROBLEMS
Academic research fraud
Billing for services not rendered
Billing fraud (not Medicaid/Medicare)
Breach of confidentiality
False or deceptive advertising
Inadequate documentation/patient records
Insurance balance billing (not Medicaid/Medicare)
Medicaid/Medicare
Medicaid/Medicare

SUPERVISION
Fully licensed physician
Limited licensee (e.g. resident)
Nurse or other employee
Physician's assistant

DIAGNOSIS RELATED
Delay in diagnosis
Failure to Diagnose
Abdominal problems (not appendicitis or ulcer)
AIDS/AIDS Related Complex/HIV
Appendicitis
Bladder problem
Bone cancer
Bowel problem
Breast cancer
Cancer (unspecified)
Cardiac disorder (not myocardial infarction)
Circulatory problem
Colon/rectal cancer
Diabetes
Eye disorder
Fracture/Dislocation
Gall Bladder disorder
Genetic disorder
Hemorrhage
Hernia
Hodgkin's disease
Implanted foreign body
Infection
Kidney disorder
Liver disorder
Liver/kidney/pancreas cancer
Lung cancer
Lyme disease
Meningitis
Myocardial infarction
Neurological disorder
Orthopedic problem (not fracture/dislocation)
Ovarian/cervical cancer
Pneumonia/pneumothorax
Respiratory problem
Skin cancer
Tendon injury
Testicular torsion
Testicular/prostate cancer
Tumor
Ulcer or complication(s) of ulcer
Failure to perform diagnostic test(s)
Lack of informed consent
Misdiagnosis
Ordering/performing unnecessary diagnostic tests/procedures

BIOMEDICAL EQUIPMENT/PRODUCT RELATED
Malfunction
Misuse

TREATMENT RELATED
Abandonment of patient
Delay in treatment
Failure to make referrals appropriately
Failure to monitor patient
Failure to notify patient of test results
Failure to take adequate patient history
Failure to treat
Failure to use consultants appropriately
Improper choice of treatment
Improper treatment of fracture/dislocation
Inappropriate admissions(s)
Inappropriate discharge(s)/transfer(s)
Lack of informed consent

Anesthesia Related
General
Allergic/adverse reaction
Failure to test improper use of equipment
Improper intubation
Improper positioning of patient
Lack of informed consent
Teeth damage
Wrong amount/type of anesthesia prescribed

Intravenous Related
CVP line
Dye reaction
General
Infiltration
Lack of informed consent

Medication Related
Drug side effect
Drug toxicity/overdose
Failure to diagnose drug addiction
Failure to diagnose drug related problem(s)
(not addiction)
Failure to prescribe
General
Lack of informed consent
Prescribing to a known addict
Wrong dose of medication
ordered/administered
Wrong medication ordered/administered

Mental Illness Related
Failure to diagnose mental disorder/illness/problem
Failure to warn third party(ies)
General
Improper commitment
Improper use of seclusion/restraints
Lack of informed consent
Suicide/suicide attempt by inpatient
Suicide/suicide attempt by outpatient

Obstetrics-Gynecology Related
Failed sterilization
Failure to diagnose ectopic pregnancy
Failure to diagnose Pregnancy, normal
Fetal death/stillbirth
Gynecology-general
Improper performance of abortion
Injury to child during labor/delivery
Injury to mother during labor/delivery
Lack of informed consent
Maternal death related to delivery
Obstetrics-general
Wrongful life/birth

Surgery Related
Delay in surgery
General
Failure to diagnose post-op complications
Improper treatment of post-op complication
Improper/negligent performance
Laceration/penetration not within scope of surgery
Lack of informed consent
Positioning-not anesthesia
Retained foreign bodies (e.g. needle, sponge)
Unnecessary surgery
Wrong body part or wrong patient

Specified Procedures/Specialties
Angiography/arteriography
Biopsy
CAT scan/MRI
Catheterization
Chemotherapy
Circumcision
Colonoscopy
Endoscopy
Injection/Immunization
Laparoscopy/laparotomy
Myelography
Neonatology
Neurology
Orthopedics
Pediatrics
Plastic/cosmetic surgery
Radiation therapy
Stress test
Suturing

TRANSFUSION RELATED
Caused AIDS/HIV
Caused hepatitis
Mismatch

MISCELLANEOUS
Improper utilization review
Improper Workmen's Compensation evaluation
Patient fall (in health care facility/office)
Performance of autopsy without permission
Unauthorized DNR order
Vicarious liability for acts of another provider
Violation of patient's civil rights
Wrongful death of patient

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SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:

- This form must be completed by a supervising physician who can evaluate your clinical performance.
- At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.
- Evaluation forms must be current within 120 days prior to Board review.
- The Evaluator must have no financial interest in your licensure in the State of Massachusetts.

I hereby authorize the representatives or staff of the facility listed below to provide the Board of Registration in Medicine with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant: ____________________________ Date: ___/___/____

Please PRINT your name: ________________________________

Name of Evaluating Hospital/Workplace: ___________________________ State: ___

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. Date(s) of applicant’s affiliation at facility (month/year)? From: _____/_____ To: _____/_____

2. In what capacity did you supervise the applicant? □ Department Chair □ Chief of Service □ Medical Director □ Training Director □ Supervising Physician □ Chief Medical Office

3. Applicant's Status: □ Intern □ Resident □ Fellow □ Staff Member □ Other __________

4. Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts? □ YES □ NO

5. Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).

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<thead>
<tr>
<th>Category</th>
<th>Superior</th>
<th>Above Average</th>
<th>Average</th>
<th>Below Average</th>
<th>Poor</th>
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<td>Clinical knowledge</td>
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<td>Clinical competency</td>
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<td>Cooperativeness/ability to work with others</td>
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(Continued on page 2)
6. Has the applicant's privileges to admit or treat patients **ever** been modified, suspended, reduced or revoked?  □ YES  □ NO (if "yes" please explain below)

7. Has this applicant **ever** been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.  □ YES  □ NO

8. Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.

9. The above comments are based on the following:
   □ Personal observation  □ General impression  □ A composite of evaluations by other physicians
   □ Other_________________________________________

10. **Recommendations:**
   □ Recommend for licensure in Massachusetts.
   □ Recommend for licensure in Massachusetts, with the following reservations:

   □ Do not recommend for the following reason(s):

   __________________________________________

   Signature of Evaluator: __________________________________________ (check one) □ M.D.  or  □ D.O.

   Name of Evaluator (Printed): __________________________________________ Date: _____/_____/_______

   Title/Position: __________________________________________________________

   E-mail address: __________________________________________ Phone number: __________________________

**PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.**
The Board and its Licensing Committee (Board) undertakes a rigorous and comprehensive process when evaluating the professional qualifications of an Applicant for a limited or initial license in Massachusetts. The honest and impartial assessment of an Applicant by his or her Program Director or Residency Director is a crucial component in the Board’s evaluative process.

All persons who submit Evaluations to the Board shall avoid any actual or perceived conflict of interest so as to ensure that the conflict does not affect patient safety, quality of care or the integrity of the services provided by the Board. A “conflict of interest” is a situation where financial, professional or personal interests (including the interests of immediate family members), may compromise one’s professional judgment or official responsibilities. A conflict of interest exists when an Evaluator may gain financially or professionally from an Applicant’s prospective employment.

All persons who submit an evaluation to the Board shall certify that they have knowledge of the Applicant’s performance and have reviewed the Applicant’s training record; that there is no evidence of any unprofessional behavior or any serious question of clinical competence; that the applicant has demonstrated competency to practice medicine without direct supervision; and that the Evaluator is the supervisor and has no conflict of interest, personally, professionally or financially, in recommending the Applicant for licensure.
### Applicant's Instructions:
Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

### Applicant's Waiver for Release of Information:
I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: __________________________ Date: ___/___/____
Print or type name: __________________________________________
License number: ___________ Status of license: [ ] Active [ ] Inactive [ ] Other ______________

### TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation: __________________________
2. Date of graduation: _____/____/____ License number: __________ Date of issue: _____/____/____
3. Basis for licensure: __________________________
   Name(s) of medical licensing examination(s)
4. Expiration date of license: _____/____/____
5. Status of license (check one): [ ] good standing [ ] revoked [ ] suspended
6. If revoked or suspended, please explain: __________________________
7. Has the licensee ever been on probation? [ ] Yes [ ] No
8. Has the licensee ever been requested to appear before the board? [ ] Yes [ ] No
   If "yes," please explain: __________________________
Other derogatory information: __________________________
Remarks: __________________________

Signed: ______________________________________________________

### BOARD SEAL

Print Name: __________________________________________________
Title: _______________________________________________________
State Board: __________________________ Date: ___/___/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.
AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____________________________________
(type or print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency (local, state, federal or foreign), law enforcement agency, or other third parties and organizations and their representatives to release information, records, transcripts and other documents concerning my professional qualifications and competency, ethics, character and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents, and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA  01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

____________________________________________  ______________________
Applicant’s Signature  Date of Signature

____________________________________________
Applicant’s Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

____________________________________________
Applicant’s Date of Birth (month/day/year)

Change of Program - Authorization for Release, Page 1 of 1, Rev. 12/14