

CHECKLIST FOR LIMITED RENEWAL APPLICATION

A limited renewal application is for physicians who are continuing in the same program. If you are changing a specialty, subspecialty or training program, you must complete a Change of Program application.

HAVE YOU

- Downloaded all of the pages of the limited renewal 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 program director or current hospital affiliation if you had a malpractice action filed against you (even if you were dismissed from the case) or if you were placed on probation or received negative reports in your training program since your last renewal? Please instruct the program director to place the evaluation in a sealed envelope and attach it to your limited renewal application.

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

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

Tel: (781) 876-8210 Website: www.mass.gov/massmedboard

RENEWAL APPLICATION - LIMITED LICENSE

Please Note: If you have questions concerning the licensing process, contact the medical staff registrar or medical education coordinator at the Massachusetts hospital where your training will be undertaken. Do not call the Board.

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 postgraduate 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 B of the Renewal and Change of Program Limited License Application forms.

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 listed on the renewal application. With a limited license, you are not allowed to “moonlight” under any circumstances.

Processing time for a Renewal Application or for a Change of Program Application is approximately four (4) to six (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 Limited License. You may not engage in any direct or indirect patient care until your limited license has been renewed.

Please be advised that your limited license expires at the end of the academic year or earlier if your training is completed before the end of the academic year. If you are continuing in a training program, a limited renewal application must be completed and sent to the Board at least 30 days prior to the end of the academic year. The Board may issue a limited license up to a maximum of 5 licenses. A request for a limited license beyond the maximum of 5 licenses may be granted only in extraordinary circumstances and is subject to review by the Board.

Renewal Application for Limited License: - The Renewal Application is to be used when the physician is continuing on in the same training program as the previous year.

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 training 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 Renewal Application must be forwarded to the training program for completion of Section B.

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. You can access the specific board's website for the verification fee. The Verification of License form must be signed and sent to the state medical licensing board(s) with the verification fee. The license verification should be returned to you. **Do not open the license verification envelope. If the seal on the envelope from the state board is broken, it will be returned to you and then you will be required to 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.

LIMITED RENEWAL INSTRUCTIONS

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 program at which you will be practicing with your Limited License.

SECTION C

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 10 and 11, 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.

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Board of Registration in Medicine - 200 Harvard Mill Square, Suite 330
Wakefield, MA 01880 Telephone: (781) 876-8210 Website: www.mass.gov/massmedboard

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Renewal fee is \$100.00. Please read the attached instructions before completing application.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

SECTION A:

1. Name: (Last) _____ (First) _____ (MI) _____
2. Mailing Address: _____ Telephone #: _____
City: _____ State: _____ Zip: _____
3. Name of Training Hospital: _____
4. Current Limited License Number: _____
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license or training license (limited).
 Full Full Limited Limited

SECTION B: To be completed by the program director.

Is the above named physician in good standing in the training program? Yes No

Has the physician been subject to past or pending disciplinary action in this program? Yes No

Print Name: _____ Date: ____/____/____

Signature of Program Director: _____ Telephone: _____

To be completed and signed by the designated official of the health care facility where the applicant has received an appointment.

This certifies that _____ has been appointed as an Intern Resident Fellow
(Name of Applicant)

Department of _____ Subspecialty _____

and as a PGY _____ or Fellowship year: _____ Academic Year: From: ____/____/____ To: ____/____/____

Is the program accredited by the ACGME: Yes | No
 If no, is there an approved ACGME program in applicant's specialty? Yes | No

Designated Official: _____ Date: ____/____/____
(Print Name)

Designated Official's Signature: _____ Telephone #: _____

Designated Official's Title: _____

NAME: _____

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

	<u>YES</u>	<u>NO</u>
6-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?	<input type="checkbox"/>	<input type="checkbox"/>
6-B. Have you, for any reason, been placed on probation in any postgraduate training program?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you voluntarily surrendered a license to practice medicine or any healing art?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
13. Have you, for any reason, withdrawn an application for hospital privileges or appointment?	<input type="checkbox"/>	<input type="checkbox"/>
14. Have you voluntarily relinquished medical staff membership?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
16. Have you been charged with any criminal offense, other than a minor traffic offense?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>

(Continued on page 3)

NAME: _____

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

- | | | <u>YES</u> | <u>NO</u> |
|-----|---|--------------------------|--------------------------|
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. | Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. | Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. | Are you currently engaged in the illegal use of drugs or misuse of prescription drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. | Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? | <input type="checkbox"/> | <input type="checkbox"/> |

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

(Continued on page 4)

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.

To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

Under the penalties of perjury, I declare that I have examined this limited renewal 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.

PRINT NAME: _____

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 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: ____/____/____

PRINT NAME: _____

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 page 4. 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):

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> 01 Emergency Room | <input type="checkbox"/> 02 Labor/Delivery | <input type="checkbox"/> 03 Laboratory/X-ray/Testing | <input type="checkbox"/> 04 Operating Room |
| <input type="checkbox"/> 05 Outpatient | <input type="checkbox"/> 06 Patient Room | <input type="checkbox"/> 07 Hospital-Other | <input type="checkbox"/> 08 Hospital-Unknown |
| <input type="checkbox"/> 09 HMO | <input type="checkbox"/> 10 Clinic | <input type="checkbox"/> 11 Nursing Home | <input type="checkbox"/> 12 Physician's Office |
| <input type="checkbox"/> 13 Walk-in Center | <input type="checkbox"/> 14 Other | <input type="checkbox"/> 15 Unknown | |

Your role (check one):

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> 01 Anesthesiologist | <input type="checkbox"/> 02 Primary Care Physician | <input type="checkbox"/> 03 Referring Physician | <input type="checkbox"/> 04 Attending Physician |
| <input type="checkbox"/> 05 Consultant Specialist | <input type="checkbox"/> 06 Surgeon | <input type="checkbox"/> 07 Fellow | <input type="checkbox"/> 08 PGY 7 |
| <input type="checkbox"/> 09 PGY 6 | <input type="checkbox"/> 10 PGY 5 | <input type="checkbox"/> 11 PGY 4 | <input type="checkbox"/> 12 PGY 3 |
| <input type="checkbox"/> 13 PGY 2 | <input type="checkbox"/> 14 PGY 1 | <input type="checkbox"/> 22 Acupuncturist | <input type="checkbox"/> 26 On-call Physician |
| <input type="checkbox"/> 27 Worker's Comp
Evaluator | <input type="checkbox"/> 28 Court Psychiatrist | <input type="checkbox"/> 24 Group Practitioner/Partner | <input type="checkbox"/> 99 Unknown |
| | <input type="checkbox"/> 98 Other | | |

(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 PendingWas the case resolved before the entry of a verdict? Yes NoWhat was the decision? Dismissed before trial Plaintiff Verdict Defense VerdictDecision determined by: Judge JuryIf 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: ____/____/____

PRINT NAME: _____

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: ____/____/____

PRINT NAME: _____

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,
EMPLOYEE(S)/PEER(S)**

Abuse of Employee(s)/Peer(s) - Physical
Abuse of Patient(s) - Physical
 Sexual misconduct
 Sexual misconduct - Verbal

ADMINISTRATIVE PROBLEMS

Academic research fraud
 Billing for services not rendered
 Billing for 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 balance billing

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 (notmyocardial 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 carefacility/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

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383
www.mass.gov/massmedboard

STATE LICENSE VERIFICATION

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 examinations(s)

4. Expiration date of license: ____/____/____

5. Status of license (*check one*): good standing revoked suspended

6. If revoked or suspended, please explain: _____

	YES	NO
7. Has the licensee ever been on probation?	<input type="checkbox"/>	<input type="checkbox"/>

8. Has the licensee ever been requested to appear before the board?	<input type="checkbox"/>	<input type="checkbox"/>
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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.

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

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 facility: _____ State: _____

INSTRUCTIONS TO THE CHIEF OF SERVICE, PROGRAM DIRECTOR OR SUPERVISOR, WHO MUST BE A PHYSICIAN: Please complete items #1-7 below and return to the applicant with your name affixed across the envelope seal.

1. How long have you worked with the applicant? From: ____/____/____ To: ____/____/____

A. In what capacity? supervisory other: _____

B. Date(s) of applicant's affiliation at facility: From: ____/____/____ To: ____/____/____

C. Applicant's Status: Intern Resident Fellow Staff Member Other _____

2. Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked? No Yes (if "yes" please explain below)

3. Please rate the following (if "BELOW AVERAGE" or "POOR", explain in detail on the back of this evaluation and/or attach a separate sheet).

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

(Continued on page 2)

4. 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. NO YES

5. PLEASE COMMENT ON THE PHYSICIAN'S STRENGTHS OR WEAKNESSES AND/OR ANY OTHER INFORMATION THAT YOU MAY HAVE TO ASSIST IN THIS EVALUATION.

6. The above comments are based on the following:

- Close personal observation
- General impression
- A composite of previous evaluations by other physicians
- Other _____

7. **RECOMMENDATIONS:**

- Recommend for licensure in Massachusetts.
- Recommend for licensure in Massachusetts, with the following reservations:

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

Signature: _____ (check one) M.D. or D.O.

Print Your Name: _____ Date: ____/____/____

Academic title or position: _____ Phone number: _____

Specialty/Service or Department: _____

E-mail address: _____

PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.



COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 300, Wakefield, Massachusetts 01880

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____
(type/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 Telephone: (781) 876-8210 Fax: (781) 876-8383
Website: www.mass.gov/massmedboard

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.

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)