

Board of Registration in Medicine
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LIMITED LICENSE RENEWAL APPLICATION INSTRUCTIONS

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GENERAL INFORMATION

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.

Limited Licensure: Limited licenses are issued to physicians enrolled in postgraduate medical education programs in healthcare facilities in the Commonwealth of Massachusetts. All such training must be done in either an ACGME-accredited or AOA-approved program, or in a fellowship program in a Massachusetts health care facility, which conducts on its premises ACGME or AOA approved programs. This information must be documented by the training program in **Section B** of this Limited License Application. A limited licensee may practice medicine only in the training program approved with their application.

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 submitted to the Board at least 30 days prior to the end of the academic year. The issuance of a limited license beyond a total of seven years of training may be granted only by a majority vote of the Board.

Practice of Medicine: Please be advised that pursuant to Massachusetts laws and regulations, you may not practice medicine in a training program until you have received a license. Both the Physician and the participating training program are responsible for determining that the Board has issued a license prior to practicing medicine.

Application Processing Time/Review: Processing time is approximately 4 to 6 weeks after the Limited License Renewal Application is received by the Board. Some applications may necessitate a longer processing time. The Board will notify the training program upon approval of the renewal of your limited license. Following the submission of your application, the Board may, at any time, request additional documentation to determine the applicant's compliance with the Board's statutes and regulations. Applicants who are not in compliance with the Board of Registration in Medicine's statutes and regulations may not be eligible for licensure.

The application review process is defined by the Board of Registration in Medicine's statutes, regulations and policies. The Board and its staff must comply with those requirements in processing applications. Applications are processed in the order in which they are received at the Board. An application will not be deemed completed and forwarded to the Board for its consideration until all required application documents and verifications are received and reviewed by Licensing Division staff.

Grounds for Denial: As an applicant, you are personally responsible for all information disclosed on your license application, including any responses that may have been completed on your behalf by others. An application may be denied based upon omission, falsification or misrepresentation of any item or response on the application or any supplemental documentation received in connection with your application. The Massachusetts Board of Registration in Medicine considers violations of an ethical nature to be a serious breach of professional conduct.

Each applicant's qualifications for licensure in Massachusetts are reviewed on an individual basis. The Board has the authority to deny licensure based upon an applicant's failure to meet the Board's requirements for licensure; failure to provide satisfactory proof of good moral character; or because of acts which, were they engaged in by a licensee, would violate M.G.L. c. 112, Section 5 or 243 CMR 1.03(5).

Interview: During the licensing process, you may be invited for a personal interview with the Board, and/or the Licensing Committee regarding your license application. Unless otherwise indicated, all meetings of the Board or any of its Committees are held at the Board office at 200 Harvard Mill Square, Suite 330, Wakefield, Massachusetts.

Limited License Renewal Application Kit

The Limited License Renewal Application Kit consists of the forms required for completing the application process. You may download additional forms on the Board's website at <http://www.mass.gov/massmedboard>.

The Limited License Renewal Application Kit is comprised of the following documents:

- Limited License Renewal Instructions
- Limited License Renewal Checklist
- Limited License Renewal Application, including Sections A, B, and C as well as the supplemental pages if you answer "yes" to any of the questions
- Authorization for Release of Information
- Supervisory Evaluation Form
- Malpractice History Request Form (only if you held a full license in another state or were named in a claim)
- Name Change form (only if you have used other names which appear on your identifying documents)

The Board may, at any time, request additional documentation to determine the applicant's compliance with the Board's statutes and regulations. Applicants who are not in compliance with the Board of Registration in Medicine's statutes and regulations may not be eligible for licensure.

Important Notes

- Read the accompanying instructions.
- Provide a complete and accurate response for every question on the application and application forms.
- Print legibly or type your answers.
- All documents should be submitted as one-sided.
- The Board requires that many documents be current within 6 months of the date of license approval; therefore, please ensure that the information you provide is current and all documents are signed and dated just prior to submission.

LIMITED LICENSE RENEWAL APPLICATION

Application Fee

The application processing fee for a limited license renewal application is \$100.00 and is non-refundable. Please make your check payable to the Commonwealth of Massachusetts. A certified check or money order is preferred, but personal checks are accepted. An application cannot be processed without the fee.

SECTION A – LIMITED LICENSE RENEWAL APPLICATION

Section A of the Limited License Application must be completed by the applicant, as well as any other corresponding forms. The applicant should forward the completed application (Section A and C and all supporting documentation) to the training program for review and completion of Section B.

2. – 3. Mailing and Email Address

The Board will use your email and current mailing address for all correspondence with you.

4. Training Facility and Specialty

Print your current training facility and training specialty.

5. Current Limited License Number

Print your Massachusetts limited license number that was issued by the Board at the time that your initial limited license application was approved. Your license number will be retained for the duration of training under a limited license.

6. Out-of-State Licensure

List all states where you currently have a full license, whether the license is active, inactive or not renewed. If none, please check the appropriate box.

7. MassHealth Enrollment

Physicians (including interns and residents) are eligible to order, refer or prescribe services for MassHealth members and, under state law, must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure. Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

MassHealth has created a Nonbilling Provider Application for providers in provider types that are not eligible to enroll as fully participating providers. This application can also be used by providers who are eligible to enroll in MassHealth as fully participating providers but who choose not to at this time. **Physicians must apply to enroll with MassHealth at least as ordering and referring (nonbilling) providers in order to obtain and maintain state licensure.** Providers who are already enrolled with MassHealth have already met the requirement and do not need to take further action.

Providers who wish to apply to enroll as nonbilling providers must download the materials from the MassHealth website at <http://www.mass.gov/eohhs/docs/masshealth/aca/pe-nbp-con.pdf> and send their completed and signed Nonbilling Provider Application and Nonbilling Provider Contract by mail to the MassHealth Customer Service Center at:

MassHealth Customer Service Center
Attn: Provider Enrollment and Credentialing
P.O. Box 121205
Boston, MA 02112-1205

Providers who have questions, or if eligible, would like to request a fully participating provider application should contact the MassHealth Customer Service Center at 1-800-841-2900 with any questions or, if eligible, to request a fully participating provider application.

SECTION B - LIMITED LICENSE RENEWAL APPLICATION

Section B of the limited license renewal application must be completed and signed by the Program Director and Designated Official at the training program/facility where the applicant has an appointment.

SECTION C- LIMITED LICENSE RENEWAL APPLICATION

Section C of the Limited License Application must be completed by the applicant, as well as any other corresponding forms. The applicant should forward the completed application (Section A and C and all supporting documentation) to the training program for review and completion of Section B.

Questions # 8-22

These questions refer to the time period since you signed your last limited application in Massachusetts. If you have any concerns on how to answer any of the questions in this section, please confirm with the primary source on how to appropriately answer the question. The Board will confirm all answers with the primary source. **For every “yes” answer you must:**

- 1) provide an explanation on the corresponding explanation page (page 6); AND
- 2) arrange for the appropriate agency or institution to submit copies of all official documentation related to the underlying occurrence or action. Documents should be sent either directly to the Board from the appropriate agency/institution or to you in a sealed envelope. If the documents are sent to you, the sealed envelopes must be included with your limited license application or sent directly to the Board unopened.

8. Answer “yes” if, since you signed your last limited application, you have been terminated from any postgraduate training program for any reason. If you answered “yes” please use the explanation page provided on page 6.

9. Answer “yes” if, since you signed your last limited application, you have been granted a leave of absence from a postgraduate training program, including a leave for research, public service, medical leave or for any other “personal reasons”. Please provide the dates and circumstances of the leave in your explanation. If you answered “yes” please use the explanation page provided on page 6.

10. Answer “yes” if, since you signed your last limited application, you have withdrawn or transferred from a postgraduate training program for any reason. If you answered “yes” please use the explanation page provided on page 6.

11. Answer “yes” if, since you signed your last limited application, you had to repeat a year of postgraduate training for any reason. If you answered “yes” please use the explanation page provided on page 6.

12. Answer “yes” if, since you signed your last limited application, you have been placed on probation, for any reasons, by a postgraduate training program. If you answered “yes” please use the explanation page provided on page 6.

13. Answer “yes” if, since you signed your last limited application, you have been denied the privilege of taking or finishing an examination or been accused of cheating and/or engaged in improper conduct during an examination. If you answered “yes” please use the explanation page provided on page 6.

14. Answer “yes” if, since you signed your last limited application, you have been denied a medical license, whether full, limited, temporary, or have withdrawn an application for medical licensure for any reason. If you answered “yes” please use the explanation page provided on page 6.

15. Answer “yes” if, since you signed your last limited application, you have voluntarily surrendered a license to practice medicine or any healing art. If you answered “yes” please use the explanation page provided on page 6.

16. Answer “yes” if, since you signed your last limited application, you have become aware of any formal disciplinary charges pending against you or if you have knowledge of any pending investigation into your professional competency or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local). If you answered “yes” please use the explanation page provided on page 6.

17. Answer “yes” if, since you signed your last limited application, 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). If you answered “yes” please use the explanation page provided on page 6.

18. Answer “yes” if, since you signed your last limited application, you have 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. If you answered “yes” please use the explanation page provided on page 6.

19. Answer “yes” if, since you signed your last limited application, you have withdrawn an application for hospital privileges or appointment, for any reason. If you answered “yes” please use the explanation page provided on page 6.

20. Answer “yes” if, since you signed your last limited application, you have voluntarily relinquished medical staff membership. If you answered “yes” please use the explanation page provided on page 6.

21. Answer “yes” if, since you signed your last limited application, your medical staff membership, medical privileges or medical staff status at any hospital has been limited, suspended, revoked, not renewed or subject to probationary conditions or if processing towards any of those ends has been instituted or recommended by a medical staff committee or governing board. If you answered “yes” please use the explanation page provided on page 6.

22. Answer “yes” if, since you signed your last limited application, your privilege to possess, dispense or prescribe controlled substances has been suspended, revoked, denied, restricted or surrendered, or if you have been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges. If you answered “yes” please use the explanation page provided on page 6.

23. Criminal History Question

Answer “yes” if, since you signed your last limited application, you have been charged with any criminal offense. This includes being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application.

If you answered “yes” please use the explanation page for question #23 located on page 7. A separate explanation page is to be used for each criminal incident. You must also arrange for the following supporting documentation to be sent directly to the Board or to you in a sealed envelope: **1) Court Records:** The appropriate court or your lawyer must send certified copies of all court records related to the offense; and **2) Police Records:** The appropriate arresting/ticketing agency or your lawyer must send certified copies of the arrest/offense/incident report or citation/ticket. If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of the applicable records, request that they furnish a written statement to that effect.

If the criminal charge(s) against you have been formally expunged or sealed the charges, offenses, arrests, tickets or citations need not be disclosed for purposes of this question. However, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

24. Medical Malpractice History Question

Answer “yes” if, since you signed your last limited application, any medical malpractice claim has been made against you, whether or not a lawsuit was filed in relation to the claim. This includes any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved or not pursued.

If you answered “yes” you must complete the explanation pages for question #24 located on pages 8-9. You must complete separate explanation pages for each malpractice claim. You must also arrange for your lawyer or liability carrier to provide the following documents directly to the Board or to you in a sealed envelope: **Pending Claim:** 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is open/pending; and 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter. **Closed Claim:** 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is closed; 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter; and 3) a copy of the final judgment, settlement and release or other final disposition of the claim, even if you were dismissed from the case by the court.

25. - 26. Confidential Information Questions

For purposes of answering questions #25 – 26, “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 impact one’s functioning as a physician, or within the past two years. **For every “yes” answer you must:**

- 1) provide an explanation on the corresponding explanation page for that question; **AND**
- 2) arrange for the appropriate agency or institution to submit copies of all official documentation related to the underlying occurrence or action. Documents should be sent either directly to the Board from the appropriate agency/institution or to you in a sealed envelope. If the documents are sent to you, the sealed envelopes must be included with your limited license application or sent directly to the Board unopened.

#25. Answer “yes” if you have a medical or physical condition that currently impairs your ability to practice medicine. If you answered “yes” you must complete the explanation page for question #24 located on page10. Your explanation of a “yes” answer should include the specifics of your condition and any related treatment, including dates and diagnoses. In addition, provide 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.

#26. Answer “yes” if you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired. If you answered “yes” you must complete the explanation page for question #25 located on page10. Your explanation of a “yes” answer should include the specifics of your treatment, if any, including dates and diagnoses. In addition, provide any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

****Important Note Regarding Physician Wellness****

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS FORM

Sign and date the Authorization for Release of Information, Documents and Records form.

SUPERVISORY EVALUATION FORM

Your training Program Director must complete the Supervisory Evaluation Form 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. The Evaluation Form must be sent to the Board in a sealed envelope.

MALPRACTICE HISTORY REQUEST FORM

Only for applicants who held a full license in any state or who were named in a medical malpractice claim while in a postgraduate training program. Complete the Malpractice History Request Form listing all liability carriers, in chronological order, beginning from the date that your first full license was issued in any state to the present. Include the liability carrier for the time period when you were in a postgraduate training program only if you had a full license OR you were named in a malpractice case during that period.

- Send a copy of the malpractice history form to all liability carriers from the date that your first full license was issued, whether or not a claim or suit was filed against you.
- Send the signed original Malpractice History Request Form back to the Board along with your application.
- If you were enrolled in a postgraduate training program, you do not need to list a liability carrier for the time period when you were in a training program unless you had a full license OR you were named in a malpractice case.

Note: If a malpractice history report is unavailable from the liability carrier due to merger or if the carrier is no longer in business, you must obtain a letter confirming the merger or closure from the liability carrier that took over in the merger or the Division of Insurance in the state where the liability carrier was registered.

STATE LICENSE VERIFICATIONS

You must obtain a written verification of every full license issued to you in the U.S., Puerto Rico or Canada in support of your application. The state boards of California, Texas, Indiana and Pennsylvania will only send license verifications directly to the Massachusetts Board of Registration in Medicine. If the other state medical board provides license verifications through Veridoc, your license verification will be sent electronically to the Massachusetts Board.

Current Probation Agreement in another State: It is the practice of the Licensing Committee, a committee of the Board of Registration in Medicine, to defer action on applications from individuals with a current probation agreement in another state, until that state's licensing board has terminated the probation.

TELEPHONE DIRECTORY AND WEBSITE ADDRESSES

| | |
|---|----------------|
| American Medical Association | (800) 621-8335 |
| www.ama-assn.org | |
| American Osteopathic Association..... | (888) 626-9262 |
| www.osteopathic.org | |
| Board of Registration in Medicine | (781) 876-8200 |
| www.mass.gov/massmedboard | |
| Education Commission for Foreign Medical Graduates (ECFMG)..... | (215) 386-5900 |
| www.ecfm.org | |
| Federal Drug Enforcement Administration (DEA) | (617) 557-2468 |
| www.deadiversion.usdoj.gov | |
| Federation of State Medical Boards (FSMB)..... | (817) 868-4000 |
| www.fsmb.org | |
| Massachusetts Department of Public Health--Controlled Substance License..... | (617) 973-0949 |
| https://www.mass.gov/orgs/massachusetts-controlled-substances-registration | |
| Massachusetts Medical Society..... | (781) 893-4610 |
| www.massmed.org | |
| National Board of Medical Examiners (NBME)..... | (215) 590-9500 |
| www.nbme.org | |
| National Board of Osteopathic Medical Examiners (NBOME)..... | (773) 714-0622 |
| www.nbome.org | |
| National Practitioner Data Bank (NPDB) | (800) 767-6732 |
| www.npdb.hrsa.gov | |

LIMITED LICENSE RENEWAL APPLICATION CHECKLIST

All documents from primary sources must be received as indicated below. If the document must be submitted in a sealed envelope, the facility seal or signature must be on the back of the envelope. DO NOT OPEN THE ENVELOPES. Please Contact the Program Coordinator at your training program if you have any questions. This checklist should be submitted to the Board with your application.

Applicant's Name (Print): _____
(First) (Middle) (Last)

Massachusetts Training Facility: _____

| DESCRIPTION OF DOCUMENTS REQUIRED TO BE INCLUDED IN YOUR INITIAL SUBMISSION | Applicant Document Checklist | For Board use only |
|--|------------------------------------|--------------------------|
| <p>Check for \$100.00</p> <ul style="list-style-type: none"> • Must be from a U.S. bank (or a U.S. money order). • Made payable to the Commonwealth of Massachusetts. • Application cannot be processed without the fee. • Application fee is non-refundable. | | |
| <p>Limited License Application – Sections A, B & C</p> <ul style="list-style-type: none"> • All fields completed. • All questions answered. • Application signed and dated. • Provide explanation for “yes” answers and additional documentation in accordance with instructions. | | |

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

LIMITED LICENSE RENEWAL APPLICATION

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

SECTION A: SWORN STATEMENT TO BE COMPLETED BY APPLICANT

1. Name: (Last) _____ (First) _____ (MI) _____
2. Mailing Address: _____ Telephone #: _____
 City: _____ State: _____ Zip: _____
3. Email Address: _____
4. Training Facility: _____ Specialty: _____

5. Current Limited License Number: _____
6. Out-of-State Licensure: List the state abbreviations where you currently have a full license. None

7. MassHealth Enrollment Requirement: (You must complete. See Instructions.)
 I am enrolled or have applied to enroll in MassHealth as a nonbilling provider.
 (Nonbilling application: <https://www.mass.gov/files/documents/2018/10/09/pe-nbp.pdf>)

SECTION B: TO BE COMPLETED BY 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
- Name of Program Director (Print): _____ Date: ____/____/____
- Signature of Program Director: _____ Telephone: _____

To be completed by the designated official of the facility where the applicant has an appointment.

- This certifies that _____ has been appointed as an Intern Resident Fellow
(Name of Applicant)
- Department of _____ Subspecialty _____
- and as a PGY _____ 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 Name (Print): _____ Date: ____/____/____
- Designated Official's Signature: _____ Telephone: _____

PRINT NAME: _____

SECTION C: TO BE COMPLETED BY APPLICANT

If you answer "YES" to any of the following questions, you must provide a detailed explanation on the corresponding explanation page and arrange for submission of the supporting documentation directly from the appropriate institution.

NOTE: The following questions refer to the period since you signed your last limited application

- | | <u>YES</u> | <u>NO</u> |
|---|--------------------------|--------------------------|
| 8. Have you been terminated from any postgraduate training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been granted a leave of absence from a postgraduate training program? (This includes a leave for research, public service, medical leave, or for any other "personal reasons".) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you withdrawn or transferred from a postgraduate training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you had to repeat a year of postgraduate training? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you, for any reasons, been placed on probation in any postgraduate training program? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. 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"/> |
| 14. Have you, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you voluntarily surrendered a license to practice medicine or any healing art? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competency or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. 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)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. 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"/> |
| 19. Have you, for any reason, withdrawn an application for hospital privileges or appointment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you voluntarily relinquished medical staff membership? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. 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 towards any of those ends been instituted or recommended by a medical staff committee or governing board? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | <input type="checkbox"/> | <input type="checkbox"/> |

PRINT NAME: _____

If you answer "YES" to any of the following questions, you must provide a detailed explanation on the corresponding explanation page and arrange for submission of the supporting documentation directly from the appropriate source.

NOTE: The following questions refer to the period since you signed your last limited application

CRIMINAL HISTORY

YES NO

23. Have you been charged with any criminal offense?

IMPORTANT NOTE: You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application.

Expunged/Sealed Offenses: While expunged offenses, arrests, tickets or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact been expunged or sealed. Failure to reveal an offense, arrest, ticket or citation that is not in fact expunged or sealed, raises questions related to truthfulness in addition to questions regarding the offense itself. **You may have been told your record is expunged or sealed when in fact it is not.** If, during the course of the application process, information about an offense is discovered which you did not disclose because you believed it to be expunged or sealed, you will be required to provide a copy of the expunction or sealing order.

MEDICAL MALPRACTICE HISTORY

YES NO

24. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

(You must report any medical malpractice claims that have been made against you, even if the claim against you was dropped, dismissed, settled, adjudicated or otherwise resolved.)

PRINT NAME: _____

CONFIDENTIAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If you answer “YES” to any of the following questions, you must provide a detailed explanation on the corresponding explanation page. 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.

- | | | <u>YES</u> | <u>NO</u> |
|------------|---|--------------------------|--------------------------|
| 25. | Do you have a medical or physical condition that currently impairs your ability to practice medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. | Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician’s participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician’s ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society’s Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

PRINT NAME: _____

CERTIFICATIONS

- Pursuant to M.G.L. c. 62C, § 49A, I certify that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to M.G.L. c. 62C, § 49A, I certify that, to the best of my knowledge and belief, I am in compliance with M.G.L. c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 112, § 1A, I certify that I will fulfill my obligation to report abuse or neglect of children as required by M.G.L. c. 119, §51A.
- By signing this form, I am providing my consent for the Massachusetts Board of Registration in Medicine and, where relevant, their supervising state agencies and the Massachusetts Executive Office of Health and Human Services and, where relevant, its provider enrollment vendor, to obtain, read, copy, and share with each other information regarding my MassHealth application and enrollment status and Massachusetts licensure status.
- I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00.
- To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.
- I certify under the penalties of perjury that all information on this form, and all attached pages, is true, accurate and complete, to the best of my knowledge and belief.

Applicant's Signature: _____ Date: ____/____/____

PRINT NAME: _____

**EXPLANATION FOR APPLICATION QUESTION #23
CRIMINAL HISTORY**

**This form must be used to provide a detailed written explanation for a “yes” response to question #23 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write “See attached”. You must provide your response on this form.
A separate form is to be used for each criminal offense/arrest.**

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the following to be sent directly to the Board or to you in a sealed envelope:
1) **Court Records:** The appropriate court or your lawyer must send certified copies of all court records related to the offense; and 2) **Police Records:** The appropriate arresting/ticketing agency or your lawyer must send certified copies of the arrest/offense/incident report or citation/ticket.
*If a court, an arresting/ticketing agency or your lawyer is unable to provide copies of the applicable records, request that they furnish a written statement to that effect.

Incident Date: ____/____/_____

Location of Incident (City and State/Country): _____

Arresting/Ticketing Agency: _____

Court: _____

Initial Charge(s): _____

_____ Misdemeanor _____ Felony

Final Charge(s): _____

_____ Misdemeanor _____ Felony

Plea: _____

Disposition: (if probation, deferred adjudication, or deferred prosecution give summary.)

Detailed Summary. Provide a personal statement containing a detailed summary of the events and circumstances leading to this arrest, citation, ticket, criminal charge and/or investigation: _____

PRINT NAME: _____

**EXPLANATION FOR APPLICATION QUESTION #24
MALPRACTICE HISTORY**

**This form must be used to provide a detailed written explanation for a “yes” response to question #24 on the Application. Please use as many forms as necessary to provide a detailed explanation.
Do not write, “See attached;” you must provide your response on this form.
A separate form is to be used for each malpractice claim.**

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for your lawyer or liability carrier to provide the following documents directly to the Board or to you in a sealed envelope:
Pending Claim: 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is open/pending; and 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter.
Closed Claim: 1) malpractice history report from your liability carrier or letter from your attorney that includes the claimant’s name/initials and confirmation that the claim is closed; 2) a copy of the Complaint, Notice of Intent to File a Claim or other claim letter; and 3) a copy of the final judgment, settlement and release or other final disposition of the claim, even if you were dismissed from the case by the court.

GENERAL CLAIM INFORMATION:

Claimant’s name/initials: _____
Date of incident: _____ / _____ / _____
Professional Liability Carrier: _____
Legal representative’s name: _____

STATUS OF CLAIM:

Current status of claim: Closed Pending

Was a lawsuit filed in relation to the claim: Yes No

If the claim resulted in a lawsuit, what was the final outcome of the suit?

Dismissed before trial Judgment for Defendant Judgement for Plaintiff

Other (please specify) _____

Was the claim settled by you or on your behalf? Yes No

If a payment was made on your behalf, either as a result of a settlement or an award of damages

Amount allocated to you: \$ _____

(Question #24 continued on next page)

**COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
www.mass.gov/massmedboard**

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)

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS: Complete this section and print your name on the top of page 2.

- 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 Officer
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).**

| | 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)

APPLICANT NAME: _____

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.

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

POLICY ON SUPERVISOR EVALUATIONS

POLICY 2017- 03

Adopted September 28, 2017

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.