Commonwealth of Massachusetts 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

IMPORTANT INFORMATION FOR THE LAPSED LICENSE APPLICANT

Welcome to Massachusetts and thank you for choosing our state to practice medicine! This application is for U.S. and international medical school graduates applying to revive their lapsed full medical license in Massachusetts.

It is extremely important that you read and follow all instructions carefully. After receipt of your application, the Board will notify you via email about any additional documentation needed--this may take up to eight weeks. The Licensing Division staff reviews applications in the order they are received.

The Board strongly recommends that you do **not** make any commitments such as home purchases, loans, etc. until you have been granted a license to practice medicine in Massachusetts.

Important Notes Regarding the Licensing Process:

- **The Board encourages you to be actively involved in the licensure process.** Follow up with third parties such as liability carriers to ensure that information is provided promptly.
- **All documents should be submitted as one-sided and must be legible.**
- Complete the application fully and accurately. If you are using a licensing service, carefully review your application prior to its submission to ensure its accuracy. You are personally responsible for all information disclosed on your application, including any responses that may have been completed on your behalf by others.
- Honestly and fully answer all questions. Your responses are evaluated as evidence of your character and fitness to practice.
- **A false response, making false statements or representations, or willfully concealing material information from the Board in connection with your application may be grounds for disciplinary action and reported to the appropriate data banks.** In such cases, an application will require Board review to determine if further action is warranted.
- It is your responsibility to notify the Board if your response to any question changes while your application is pending. You must immediately notify the Board of the new information.
- **Documents must be current within 6 months of the date of license approval.** Please ensure that the information you provide is current and all documents are **signed/dated just prior to submission**.
- Questions should be directed to the Licensing Analyst assigned to your application.
- Please refer to the Application Instructions posted on the Board's website for additional information.

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LAPSED LICENSE APPLICATION CHECKLIST

Listed below are the minimum application and supporting materials required to revive your lapsed Massachusetts medical license. This list is not all-inclusive; additional items may be necessary based on responses provided on your Application or information obtained from other sources. For further information please see the *Lapsed License Application Instructions* posted on the Board's website: www.mass.gov/massmedboard.
Please confirm that documents listed on this checklist are included with your lapsed license application.

INFORMATION REQUIRED FROM APPLICANT

☐ **Application Fee**	**Check for $700.00** • 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.
☐ **Lapsed License Application**	• All fields completed and all questions answered. • Timeline from date of medical school graduation to the present, including all professional and non-professional activities with no gaps of 30 days or more. • "Yes" answers to any Application Question (#21-37) requires an explanation on the appropriate Explanation page and submission of supporting documentation, where required. Application Questions #21-37 refer to the period of time since the date you signed your last Massachusetts license application to the present. • Recent 2 inch x 2 inch color photo attached. • Application signed, dated and notarized by a U.S. notary. Please sign/date your application just prior to submission to ensure all information is up-to-date.
☐ **CORI Acknowledgment Form**	• Must be notarized by a U.S. notary. • All fields with an asterisk are mandatory. • *As part of the general background check for licensing purposes, the Board receives Criminal Offender Record Information ("CORI") from the Massachusetts Department of Criminal Justice Information Systems.*
☐ **Liability Carrier Request Form**	• You must submit with your application the original Liability Carrier Request Form listing all liability carriers for the applicable time period, as noted below. • **License Lapsed Under 10 Years**: List your liability carriers, in chronological order, **beginning from the time you signed your last Massachusetts license application to the present.** • **License Lapsed for 10 Years or More:** List your liability carriers, in chronological order, **for the past 10 years.** If named in a **malpractice claim during the time period that your license was lapsed,** you must also list your carrier for that time period, even if the claim was made more than 10 years ago. • Provide copies of his Form to each liability carrier in order to request a claims history report be sent to the Board.
☐ **Curriculum Vitae (CV)**	• Submit a current CV (no formatting requirements).
Personal Interview *(if applicable)*	• You will be notified if a personal interview will be required.

DOCUMENTS REQUIRED FROM THIRD PARTIES	
All documents from third parties must be received as indicated below. Do not open the sealed envelopes. Asterisk(*) denotes that the sealed envelope must have the facility seal or signature on the back of the envelope.	
☐ **Supervisory Evaluation Form** **(*sealed envelope)**	• Completed by a supervising physician (e.g. CMO; Department Chair; or physician who evaluates your clinical activities). • If currently in training it must be completed by a Program Director. • The evaluator must have no financial interest in your licensure. • Evaluations must cover at least one year of current clinical activities. If you have been practicing at a facility for less than one year, you must request additional Evaluation Forms from previous supervisors to cover a full year. • Locum tenens physicians must have evaluations from the most recent two years of assignments.
☐ **AMA or AOA Physician Profile** **(sealed envelope or electronically)**	• Request that either one of the following be submitted to the Board: o AMA Physician Profile (https://commerce.ama-assn.org/amaprofiles/); or o AOA Osteopathic Physician Profile (www.osteopathic.org)
☐ **National Practitioner Data Bank (NPDB)** **(sealed envelope)**	• Request a paper copy of your self-query profile from the NPDB at www.npdb-hipdb.hrsa.gov • Mail the **unopened/sealed** NPDB Profile directly to the Board.
☐ **Liability Carrier Claims History Reports** **(directly from liability carrier or sealed envelope)**	• A Claims History Report must be received from every liability carrier listed on your Liability Carrier Request Form. • **License Lapsed Under 10 Years**: A Claims History Report must be received from every liability carrier, **beginning from the time you signed your last Massachusetts license application to the present.** • **License Lapsed for 10 Years or More:** A Claims History Report must be received from every liability carrier **for the past 10 years.** If named in a **malpractice claim during the time period that your license was lapsed**, you must also request that your carrier for that time provide a claims history report, even if the claim was made more than 10 years ago.

MA License Number: _____

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LAPSED LICENSE APPLICATION

Non-refundable Application Fee: A $700.00 check or money order payable to the Commonwealth of Massachusetts must be included with your lapsed license application.

PERSONAL INFORMATION

1. Legal Name	**Last**	**First**	**Middle**	**Suffix**
2. Other Name(s) List other names that appear on your application documents (medical education, exams, etc.)				
3. Degree Type	☐ M.D. ☐ D.O. ☐ Other degree: _____			
4. Social Security Number				
5. NPI Number				
6. Date of Birth	_____ Month Day Year	**7. Place of Birth**	**City/State**	**Country if not USA**
8. Mailing Address This address will be used for correspondence	**Number and Street**			
	City	**State/Province/Territory**	**Zip (or postal) Code**	
9. Home Address	**Number and Street**			
	City	**State/Province/Territory**	**Zip (or postal) Code**	
10. Business Address	**Number and Street**			
	City	**State/Province/Territory**	**Zip (or postal) Code**	
11. Telephone Numbers	**Home #**	**Business #**	**Cell #**	
12. Email Address Will be used for correspondence				

PRINT NAME: _____

Questions #13 – 15 are optional. This information will assist the Board in processing your application.	
13.	**Reason for requesting revival of your lapsed Massachusetts medical license:**
14.	**Name of anticipated practice location/facility:** _____ Address: _____ City: _____
15.	**Anticipated starting date in Massachusetts:** _____

U.S. OR CANADIAN MEDICAL LICENSURE	
16.	**If you <u>currently</u> or have <u>ever</u> held a full license in the U.S. or Canada list the state/province abbreviation. This includes any active or inactive licenses. Do not report training or temporary licenses.**

PRACTICE SPECIALTY	
17.	**List the medical specialt(ies) that you practice. The specialties listed will be included on your Physician Profile on the Board's website to help consumers locate physicians in specific specialties.**

ABMS/AOA BOARD CERTIFICATION	
18.	**Are you certified by the American Board of Medical Specialties (ABMS)?** ☐ Yes ☐ No If "Yes", list Board Certification(s):_____
19.	**Are you certified by the American Board of Osteopathic Medicine (AOA)?** ☐ Yes ☐ No If "Yes", list Board Certification(s): _____

PRINT NAME: _____

PRACTICE OF MEDICINE

You must answer "yes" or "no" to question #20. A "no" response requires an explanation below.

NOTE: Pursuant to Board procedure, an applicant who has not been engaged in the continuous practice of medicine during the past two years, may be reviewed by the Board's Licensing Committee and may be requested to return to the clinical practice under a period of supervision. Please see the Application Instructions on the Board's website for further information. www.mass.gov/massmedboard.

20.	**Have you been engaged in the continuous practice of medicine during the past two years?** ☐ Yes ☐ No	

If "No", please provide an explanation, including, but not limited, to the date of your most recent clinical practice, the reason(s) for time away from the practice of medicine, a brief description of your activities during this time and anticipated return to practice plans.

PRINT NAME: _____

TIMELINE OF ACTIVITIES SINCE GRADUATION FROM MEDICAL SCHOOL

Please provide a chronological listing by month and year of ALL activities since graduation from medical school. You must include postgraduate training, research activities, hospital affiliations, medical staff appointments, faculty appointments, private practices, locum tenens and telemedicine assignments and any other employment or volunteer activities. Also include periods of unemployment or any activities outside of the practice of medicine. Do not write, "See CV" or "See attached"; you must complete this section AND attach your curriculum vitae. If you need additional rows, please print additional copies of this page. **You MUST account for any time gaps of 30 days or more since your graduation from medical school. (*For example, if you graduated from medical school on May 31, 2015 and started residency on July 1, 2015, you must account for this gap of 30 days.*)**

Start Date (mm/yyyy)	**End Date** (mm/yyyy)	**Position Held** (Resident, Attending, Research Fellow, etc.)	**Institution/Place of Employment**	**City, State/Country**
Month Year		**Medical School Graduation Date** *(start timeline from this date)*		

PRINT NAME: _____

APPLICATION QUESTIONS

For purposes of questions # 21 – 37, the time period is from the date you signed your last Massachusetts license application to the present. You must answer "yes" or "no" to each question.

NOTE: A "yes" response requires a detailed explanation on the *Explanation for Application Questions* page and submission of documentation related to the underlying occurrence from the appropriate institution.

	ACTIONS BY ANY HEALTHCARE FACILITY, EMPLOYMENT, PROFESSIONAL ORGANIZATION, STATE BOARD OR ANY OTHER GOVERNMENTAL AGENCY	YES	NO
21.	Have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?	☐	☐
22.	Have you been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?	☐	☐
23.	Have you surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)	☐	☐
24.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification been suspended or revoked?	☐	☐
25.	Are you aware of any open complaint, pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?	☐	☐
26.	Has any disciplinary action been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)	☐	☐
27.	Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competency to practice medicine?	☐	☐
28.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility 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, administration or governing board?	☐	☐
29.	Have you withdrawn an application for hospital privileges or appointment, or have you been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?	☐	☐
30.	Has your privilege to manufacture, distribute, administer, 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?	☐	☐
31.	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?	☐	☐
32.	Have you had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?	☐	☐

PRINT NAME: _____

EXPLANATION FOR APPLICATION QUESTIONS

This form must be used to provide a detailed written explanation for a "yes" response to Questions # 21 - 32 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 question.

SUPPORTING DOCUMENTATION: In addition to the below explanation, you must arrange for the appropriate agency or institution to submit copies of all official documentation related to any "yes" response to a question on the Application. Documentation should be sent directly to the Board or to you in a sealed envelope.

Application Question Number: _____ (List the corresponding question number - # 21 - 32)

Name of agency or institution taking action: _____

Date(s): _____ _____ _____ - _____ _____ _____

Please provide a detailed explanation:

PRINT NAME: _____

MEDICAL MALPRACTICE HISTORY QUESTION			
For purposes of question #33, the time period is from the date you signed your last Massachusetts license application to the present. You must answer "yes" or "no" to question #33. **NOTE: A "yes" response requires a detailed explanation of each malpractice claim. Please use the *Explanation for Malpractice History Question.* You must also arrange for your lawyer or liability carrier to provide the requested supporting documentation.**		**YES**	**NO**
33.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? **NOTE:** 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.	☐	☐

CRIMINAL HISTORY QUESTION			
For purposes of question #34, the time period is from the date you signed your last Massachusetts license application to the present. You must answer "yes" or "no" to question #34. **NOTE: A "yes" response requires a detailed explanation of each offense/arrest. Please use the *Explanation for Criminal History Question*. You must also arrange for submission of the court and police records directly from the primary source or from your lawyer.**		**YES**	**NO**
34.	Have you been charged with any criminal offense? **NOTE:** You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed or otherwise discharged. Minor traffic or parking violations need not be reported. You must report serious traffic offenses such as reckless driving, hit and run, driving with a suspended license, or operating under the influence or its equivalent. This list is not all-inclusive. If in doubt as to whether an arrest or criminal offense must be disclosed, it is best to disclose the action on your application. A medical malpractice claim is a civil, not a criminal matter and should not be reported on this question. Expunged/Sealed Offenses: While expunged/sealed 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.	☐	☐

PRINT NAME: _____

EXPLANATION FOR MALPRACTICE HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #33 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: $_____

(*Explanation for Malpractice History Question* continued on the next page)

PRINT NAME: _____

MALPRACTICE EXPLANATION CONTINUED

MALPRACTICE CLAIM DESCRIPTIVE INFORMATION:

Allegation(s): _____

_____

Alleged Patient Injury: _____

_____

Condition of Patient When You Began Treatment: _____

_____

Condition of Patient at the End of Treatment: _____

_____

Detailed Summary: Provide a detailed narrative of the clinical course and circumstances leading to the claim, including the nature and extent of your involvement and role in patient the care.

PRINT NAME: _____

EXPLANATION FOR CRIMINAL HISTORY QUESTION

This form must be used to provide a detailed written explanation for a "yes" response to question #34 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 the criminal offense:

PRINT NAME: _____

CONFIDENTIAL INFORMATION QUESTIONS			
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, <u>or</u> within the past two years. You <u>must</u> answer "yes" or "no" to questions #35 - 37. **NOTE: A "yes" response to questions #35 - 37 requires a detailed explanation. Please use the *Explanation for Confidential Information Questions.***		**<u>YES</u>**	**<u>NO</u>**
35.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?	☐	☐
36.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?	☐	☐
37.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?	☐	☐

**** 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.

PHS is a nationally recognized physician assistance program designed to assist physicians with the following: alcohol misuse; substance use disorder; behavioral or mental or physical health issues that currently impair the ability to practice medicine; stress including administrative burdens; financial pressures; and work-family balance issues. PHS does not treat but may refer a physician for evaluation and treatment, if necessary. PHS services are available to all physicians in Massachusetts, whether or not they belong to the Massachusetts Medical Society.

PRINT NAME: _____

EXPLANATION FOR CONFIDENTIAL INFORMATION QUESTIONS

QUESTION #33 – Medical or physical condition.

Please provide 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.

QUESTION #34 – Substance use.

If you have obtained medical treatment related to your use of substances, please provide the specifics of your 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 use of substances on your current practice, including participation in any supervised rehabilitation program or monitoring program.

QUESTION #35 - Refusal to take a screening test for chemical substances.

Please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

PRINT NAME: _____

STATUTORY AND REGULATORY REQUIREMENTS FOR LICENSURE

NOTE: You must complete the following requirements. Please see the Instructions for further information.

38. **Continuing Medical Education (CME) Requirements: (You must check one.)**

☐ I completed no fewer than 100 CME credits, of which a minimum of 40 credits were Category 1 and 60 were Category 2, during the past two years including, but not limited to, the following CME credits:

- 10 CME credits must be in the area of Risk Management, at least 4 credits shall be Category 1;
- 2 CME credits studying the Board's regulations, 243 CMR 1.00 through 3.00;
- 2 CME credits in end-of-life care issues (This is a one-time requirement.); and
- 3 CME credits in opioid education and pain management training, if you prescribe controlled substances (Schedules II – VI). (i.e., www.opioidprescribing.com)

☐ I am exempt from the CME requirement due to my current participation in postgraduate training.

39. **Child Abuse or Neglect Recognition and Reporting Training: (You must check one.)**

☐ I received training in child abuse and neglect assessment in medical school or postgraduate training.

☐ I completed a hospital sponsored training program in recognizing the signs of child abuse and neglect.

☐ I completed a CME program in identifying and reporting child abuse and neglect.

☐ I completed an online training program (i.e. The Middlesex Children's Advocacy Center's program "51A Online Mandated Reporter Training: Recognizing and Reporting Child Abuse, Neglect and Exploitation" www.middlesexcac.org/51A-reporter-training).

☐ I completed a specialized certification (i.e., Child Abuse Pediatrics)

40. **Domestic and Sexual Violence Education and Training: (You must complete.)**

☐ I completed the Massachusetts Department of Public Health online training in Domestic and Sexual Violence for licensed healthcare professionals.
https://www.mass.gov/service-details/domestic-and-sexual-violence-integration-initiatives

41. **MassHealth Enrollment Requirement: (You must check one.)**

☐ I am enrolled or have applied to enroll in MassHealth as a nonbilling provider.
(Nonbilling application: https://www.mass.gov/doc/nonbilling-orp-provider-contract-and-application-3/download)

☐ I am enrolled or have applied to enroll in MassHealth as a billing provider.
(Billing provider application must be requested through MassHealth at 1-800-841-2900)

42. **Electronic Health Records (EHR) Proficiency Requirement: (You must check one.)**

I have DEMONSTRATED PROFICIENCY in the use of EHR through my:

☐ participation in a Meaningful Use program as an eligible professional.

☐ my employment with, credentials to provide patient care at, or contractual agreement with an eligible hospital or critical access hospital that has implemented an electronic health record.

☐ participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.

☐ completion of 3 hours of a Category 1 EHR-related CME course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

OR

I am EXEMPT from the EHR Proficiency requirement because I am an applicant:

☐ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4).

☐ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis.

PRINT NAME: _____

90-DAY RENEWAL INFORMATION

State law requires that renewal of your license occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday.

Example: If your birthday is July 1, 2014, and your license is issued on May 1, 2014, your renewal date will be July 1, 2015. However, if your birthday is July 1, 2014, and your license is issued on January 1, 2014, you will be required to renew your license by your birthday on July 1, 2014. Renewals thereafter will be on a two-year birthday cycle.

Check one:

☐ Do not hold my Lapsed License Application; send it to the Board as soon as it is completed.

☐ Hold my Lapsed License Application until it is within the 90-day time period.

My birthday is: _____
Month Day Year

CERTIFICATIONS

- I understand and agree to comply with the following obligations:
  - report abuse or neglect of children and report a child suffering physical or emotional injury resulting from being a human trafficking victim pursuant to G.L. c. 119, § 51A and I understand the punishment for failure to comply.
  - report abuse or neglect of disabled persons pursuant to G.L. c. 19C, § 10 and I understand the punishment for failure to comply.
  - report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A,§ 15 and I understand the punishment for failure to comply.
  - report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, §12A and I understand the punishment for failure to comply.
  - report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, § 12A 1/2 and I understand the punishment for failure to comply.
  - report a physician to the Board of Medicine pursuant to G.L. c. 112,§ 5F, when I have a reasonable basis to believe that a person violated any provisions of G.L. c. 112 § 5 or any Board regulation.
  - related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule pursuant to G.L. c. 112, § 2.
  - file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to G.L. c. 62C, § 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
  - related to the reporting of the wages of employees and contractors pursuant to G.L. c. 62E, § 2.
  - related to the withholding and remitting of child support payments pursuant to G.L. c. 119A.
  - file an Incident Report with the Board when certain adverse events occur in my private office pursuant to G.L c. 112, § 5 and 243 CMR 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
  - disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L c. 112, § 12AA.
- I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number. I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- I understand that as an applicant to revive my license, a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- By signing this application, 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.

Certification:

☐ **I confirm I have read and agree to comply with these statutory and regulatory requirements.**

DECLARATION OF APPLICANT

I, _____:

(PRINT LEGAL NAME)

being duly sworn, depose and say that I am the person described and identified in this application. I declare that I have examined this complete application and to the best of my knowledge and belief, the information contained herein and evidence or other credentials submitted herewith are true, correct and complete. **I understand that any falsification or misrepresentation of any item or response on this application or any attachment hereto may be a sufficient basis for revoking a license.** I hereby 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 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. I hereby authorize the Board of Registration in Medicine to transmit any information contained in the application, or information that may otherwise become available to them, to any agency, organization, or individual, who, in the judgement of the Board, has a legitimate interest in such information.

SIGNATURE: _____ DATE: _____

PHOTOGRAPH

Photograph

Attach a recent 2 inch x 2 inch color photograph. Black and white photographs will not be accepted.

SIGNATURE OF APPLICANT:

_____

(Sign in the presence of a notary)

NOTARY SECTION

NOTARY: I certify that the photograph above is a genuine likeness of the marker of the signature above.

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____

Signature of Notary Public

_____

Commission Expires On

NOTARY SEAL

Commonwealth of Massachusetts 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

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGMENT FORM

The Board of Registration in Medicine is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening license applicants.

As a license applicant, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to the Board of Registration in Medicine to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Board of Registration in Medicine written notice of my intent to withdraw consent to a CORI check.

The Board of Registration in Medicine may conduct subsequent CORI checks within one year of the date this form was signed by me provided, however, that the Board of Registration in Medicine must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgment Form is true and accurate.

Signed under the penalties of perjury, this _____ day of _____, 20 ____.

_____
Signature of Applicant

_____
Print Name

(Continued on next page)

SUBJECT INFORMATION: An asterisk (*) denotes a required field			
***Legal Name**	***Last** ***First** **Middle** **Suffix**		
***Maiden Name or other name(s) by which you have been known**	***Last** ***First** **Middle** **Suffix**		
***Date of Birth**	_____ _____ _____ Month Day Year	***Place of Birth**	
***Last Six Digits of Your Social Security Number**			
Sex		**Height**	_____ft. _____in.
Eye Color		**Race**	
Driver's License or ID Number		**State of Issue**	
Mother's Full Maiden Name		**Father's Full Name**	
Current and Former Addresses	**Number and Street** **City/Town** **State** **Zip**		
	Number and Street **City/Town** **State** **Zip**		

NOTARY SECTION

On this _____ day of _____, 20_____, before me, the undersigned notary public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of identification, which were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

_____
Signature of Notary Public

_____
Commission Expires On

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SUPERVISORY EVALUATION FORM

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

- This form must be completed by a supervising physician who can evaluate your clinical performance.
- If currently in training it must be completed by a Program Director.
- Evaluations must cover at least one year of current clinical activities. If you have been practicing at a facility for less than one year, you must request additional Evaluation Forms from previous supervisors to cover a full year.
- Locum tenens physicians must have evaluations from the most recent two years of assignments.
- The Evaluator must have no financial interest in your licensure in 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: _____

Applicant PRINT name:_____

Name of Evaluating Hospital/Workplace:_____ State: _____

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete both pages 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 ☐ Training Director ☐ Supervising Physician ☐ Chief Medical Officer ☐ Medical Director

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?** ☐ YES ☐ NO

5. **Please rate the applicant. 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	☐	☐	☐	☐	☐
Relationships with patients	☐	☐	☐	☐	☐
Cooperativeness/ability to work with others	☐	☐	☐	☐	☐

(Continued on next page)

6.	**Has the applicant's privileges to admit or treat patients <u>ever</u> been modified, suspended, reduced or revoked?** If "yes" please explain below. ☐ YES ☐ NO
7.	**Has this applicant <u>ever</u> 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.	**<u>Recommendation</u>:** ☐ Recommend for licensure in Massachusetts. ☐ Recommend for licensure in Massachusetts, with the following reservations: _____ _____ ☐ Do not recommend for the following reason(s): _____ _____

SUPERVISING PHYSICIAN SIGNATURE

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

Print Name:_____ Date: _____

Title/Position: _____

E-mail:_____ Phone number:_____

RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR <u>SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL</u>.

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LIABILITY CARRIER REQUEST FORM

Applicant Print Name: _____

APPLICANT INSTRUCTIONS: **Print name above**. Send a copy of the completed form to each carrier in order to request a claims history report. Send the original form to the Board with your application.

- **License Lapsed Under 10 Years**: In chronological order, list your liability carriers **beginning from the time you signed your last Massachusetts license application to the present.**
- **License Lapsed for 10 Years or More:** In chronological order, list your liability carriers **for the past 10 years.** If **named in a malpractice claim during the time period that your license has been lapsed**, you must also list your carrier for that time period, even if the claim was made more than 10 years ago.

Liability Carrier			
Dates of Coverage	To: _____ _____ From: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	To: _____ _____ From: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	To: _____ _____ From: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	To: _____ _____ From: _____ _____	**Policy Number**	
Liability Carrier			
Dates of Coverage	To: _____ _____ From: _____ _____	**Policy Number**	

LIABILITY CARRIER INSTRUCTIONS: Please provide the following documentation directly to the Board at the above listed mailing address or via email at: malpractice.reports@MassMail.State.MA.US. If sending documents via email, you must include the physician's name in the subject line of the email.

Claims History Report/Loss Run Report: Please provide a claims history report on letterhead, which includes:

1. Policy number
2. Dates of policy coverage;
3. If your company's name has changed, please provide any former company names.
4. Whether the applicant has any claims history;
5. If the applicant has a claims history, please include:
    a. the name/initials of the claimant(s);
    b. nature and date of claim(s);
    c. whether the claim is pending or closed. If closed, final disposition; and
    d. amounts paid on the applicant's behalf, if any.

Additional Claim Documentation: If the applicant has a claims history, please provide copies of the following:

1. Complaint, notice of intent to file a claim, or other claim letter; and
2. Final judgment, settlement and release, or other final disposition of each claim.