



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

REACTIVATION FROM RETIREMENT APPLICATION

Please read the Reactivation From Retirement Application Instructions before sending your application and fee of \$600.00 to the Board. Every question on the application and supplement must be answered. If you answer “yes” to any question on the supplement, # 1-17, you must also provide the additional information requested on the supplement.

When you receive the National Practitioner Data Bank Profile, attach it to your completed license application and mail the packet to the Board of Registration in Medicine at the above-listed address. Do not open the National Practitioner Data Bank Profile envelope. If the seal on the envelope is opened, the Board will not accept the contents of the envelope; it will be returned to you and you will have to repeat the process. Please mail all of the required documents together.

If you have any malpractice or legal issues, the information must be sent directly to you from your liability carrier or attorney.

Thank you.

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

Reactivation from Retirement
Application Instructions

TABLE OF CONTENTS

Application Fee.....	2
Practice of Medicine	2
Application Instructions.....	2
Social Security Number	2
Postgraduate Education and Hospital Appointments.....	2
Medical Malpractice Insurance.....	2
Continuing Professional Development (CPD) Requirements.....	2
Supplement to Application	3
Office Based Surgery	4
Malpractice Cases	4
Malpractice History Form.....	4
Legal Issues.....	4
Authorization for Release of Information	4
Medicare/Tax Form	5
AMA or AOA Physician Profile.....	5
National Practitioner Data Bank	5
License Processing Time	5
Controlled License Substance Registration and DEA Registration.....	5
Address Change	6
Birth Date Renewal.....	6
Telephone Directory and Website Addresses	7

APPLICATION FEE

The processing fee for reactivation from retirement is non-refundable. Please make a check in the amount of \$600.00 payable to the Commonwealth of Massachusetts. A certified check or money order is preferred, but personal checks are accepted. Applications unaccompanied by the reactivation from retirement fee will not be processed.

PRACTICE OF MEDICINE

The “practice of medicine” is defined in the Board’s regulations, in part, as the following conduct: diagnosis, treatment, use of instruments or other devices, or the prescription or administration of drugs for the relief of diseases or adverse physical or mental conditions. A person who holds himself out to the public as a “physician” or “surgeon” or with the initials “M.D.” or “D.O.” in connection with his name and who also assumes responsibility for another person’s physical or mental well-being is engaged in the practice of medicine.

APPLICATION INSTRUCTIONS

Social Security Number: Your social security number may be used to facilitate the authorized sharing of information with designated agencies for identification of licensees for the following purposes: reporting of disciplinary actions to national data reporting systems; tax default status; student loan default status; child support arrearages; Medicaid provider eligibility; possession of Massachusetts controlled substances registration; and collection of fines from Board disciplinary case. Pursuant to 42 U.S.C. § 405 (c) (2) (c) (i), (v), (vi) and M.G.L. c. 30A, § 13A, and M.G.L. c. 119A, § 16, you are required to provide this information. The Board considers this information highly confidential and it is not subject to release, except as specifically authorized.

Postgraduate Education and Hospital Appointments: Chronologically list and date all educational and professional training experience and employment from the date of graduation from medical school to the present. Account for all periods of time, whether or not you were engaged in the practice of medicine. Also enclose a copy of your updated curriculum vitae by month and year.

Medical Malpractice Insurance: Indicate whether your medical malpractice insurance is covered by an insurance carrier or letter of credit. You must have malpractice coverage before your reactivation from retirement can be revived, unless you are exempt.

Continuing Professional Development Requirements (formally known as Continuing Medical Education): In the blanks provided, list the manner in which you completed your CPD requirements during the past two years. Unless exempt, you must list the number of Category 1 and 2 credits you have completed. Licensees enrolled in residency and clinical fellowship programs are exempt from the CPD requirement until the first full license renewal cycle that begins after their program has ended.

Otherwise, you must have met the basic CPD requirements for the two-year period ending on the date you sign this form. A brochure with more complete information on the CPD requirements is available on the Board’s web site at www.mass.gov/massmedboard.

The basic CPD requirement for a two (2) year cycle requires no fewer than 100 hours of CPD credit with the following components:

- (a) At least 40 credit hours in Category 1 programs (the entire 100 hour requirement may be met by earning Category 1 credits);
- (b) Up to 60 credit hours in Category 2 activities;
- (c) Ten credit hours of risk management study (see below), with at least 4 hours in Category 1;
- (d) Two credit hours by studying the Board's regulations in either Category 1 or 2;
- (e) Two credit hours of end-of-life care issues in either Category 1 or 2. These credits may be used toward risk management credits. This CPD requirement is mandatory for all physicians regardless of specialty. Physicians may find a free online course at <http://www.eolcounseling.com> or may contact the Massachusetts Medical Society. Pediatricians may wish to check with the American Academy of Pediatrics for courses in Palliative Care for Children.
- (f) As of February 1, 2012, physicians who prescribe controlled substances (Schedules II - VI) must have completed at least three (3) credit hours of Board-approved CPD in effective pain management, which shall include training in how to identify patients at high risk for substance abuse and training in how to counsel patients about side effects, the addictive nature, and proper storage and disposal of prescription medicines. Please remember that all prescription drugs are controlled substances in Massachusetts.

Physicians are responsible for determining whether the pain management CPD requirement applies to them, based upon the nature of their practice. A free online resource to obtain the necessary credits is available at www.opioidprescribing.com. The three (3) credit hours of opioid and pain management training will qualify as either Category 1 or Category 2 credits and may be used as risk management credits for continuing professional education.

- (g) A majority of the total 100 credit hour requirement must be in the licensee's primary area(s) of practice.

"Risk management study" must include instruction in medical malpractice prevention, such as risk identification, patient safety and loss prevention, and may include instruction in any of the following areas: medical ethics, quality assurance, medical-legal issues, patient relations, utilization review that directly relates to quality assurance, non-economic aspects of practice management, electronic health records, end-of-life care issues and opioid and pain management.

SUPPLEMENT TO APPLICATION

Instructions for answering the questions on the Supplement Form are included in the application package. All of the questions on the Supplement Form must be answered "YES" or "NO." Please be careful in matching your answers to questions, because incorrect answers will jeopardize and delay processing of your application. Pages 5-10 must be completed if you answer "YES" to any question(s).

OFFICE BASED SURGERY

“Surgery” means those procedures defined in the Massachusetts Medical Society (MMS) Office Based Surgery Guidelines under the following specific definitions: “Surgery;” “Office Based Surgery;” “Major Surgery;” “Minor Surgery;” and “Special Procedure.” You must complete the Office Based Surgery form if you perform any procedures in your office that are described in these definitions. (*MMS Office Based Surgery Guidelines have been endorsed by the Board and are available through the MMS and Board websites: www.massmed.org and www.mass.gov/massmedboard.*)

MALPRACTICE CASES

If you have had a malpractice case brought against you, you will need to either request that your liability carrier or your attorney forward a copy of the documents to you and you must forward them to the Board in the sealed envelope with your reactivation from retirement application. If a malpractice case is open, closed or dismissed against you, your liability carrier or attorney must indicate that fact to the Board in a letter containing the claimant’s name or initials. If the malpractice case is dismissed, please include the date of dismissal and a statement if no monies were paid to the claimant on your behalf. Your liability carrier or lawyer must also provide a copy of the complaint or summons or dismissal for every malpractice case filed against you. You must complete question #14 on the Supplement Form even if a complaint was filed against you, but did not result in any action.

MALPRACTICE HISTORY FORM

Complete the malpractice history form listing all liability carriers from the time you completed your postgraduate training 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 whether or not a claim or suit was filed against you.
- You must include with your full license application: the original malpractice history form and the malpractice history reports received from your liability carriers detailing your medical malpractice history during the period of your coverage.
- When you receive your malpractice history report from your liability carrier, you should review it for accuracy and ensure that you have reported all malpractice cases to the Board
- You should make a copy of the malpractice history reports received from your liability carriers for your records and to ensure that you are aware of all instances where you have been named in a medical malpractice claim.
- You do not need to list a liability carrier for the time period when you were in a training program unless had a full license or you were named in a malpractice case.
- Complete a supplement form for each medical malpractice claim whether the case is open, closed or dismissed and follow the instructions on the supplement for the additional documents to be included with your full license application.

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 Division of Insurance in the state where the liability carrier was registered.

LEGAL ISSUES

For each criminal proceeding in which you were named a defendant, certified copies of the complaint, judgment or other disposition must be sent to the Board by your lawyer, the court or other appropriate agency. You must also provide a detailed explanation of the incident, including date, time, place, who was with you, and the court action.

AUTHORIZATION FOR RELEASE OF INFORMATION

The Authorization for Release of Information form must be completed and returned to the Board with your application.

MEDICARE/TAX FORM

All applicants for Massachusetts medical licensure must complete this form.

AMA OR AOA PHYSICIAN PROFILE

You may request an AMA Physician profile on line by visiting <http://www.ama-assn.org/AMAProfiles> and your AMA profile will be sent directly to the Board, or you may contact the AMA Customer Service for ordering assistance at (800) 665-2882 or (312) 364-5199. Contact the American Osteopathic Association (AOA) for the AOA Physician profile at www.osteopathic.org for the AOA Physician profile.

NATIONAL PRACTITIONER DATA BANK

To request a National Practitioner Data Bank Profile, please visit <http://www.npdb-hipdb.hrsa.gov/> and complete the Self-Query form online. After completing the Self-Query form, you must print out a hard copy, have it notarized and forward it to the Data Bank. Please note that the date of your signature and notary date must be the same, otherwise the Self-Query form will be returned to you, delaying processing of your application. Also note that the Self-Query fee is payable by CREDIT CARD ONLY (Visa, MasterCard, Discover). Please remember to include your credit card number and expiration date on your query form. You must request your National Practitioner Data Bank Profile to be sent to you in a sealed envelope and forwarded to the Board with your reactivation from retirement application.

LICENSE PROCESSING TIME

Do not send your reactivation from retirement application to the Board until you receive the National Practitioner Data Bank profile and your malpractice history reports or malpractice documents in sealed envelopes. It takes approximately four weeks, after the required documents are received by the Board, to process a reactivation from retirement application that: a) retired in less than two years; and b) where

there are no legal or malpractice issues. When a licensee applies to revive a license and more than two years have passed, the application must be reviewed by the Licensing Committee. The Licensing Committee meetings are held once a month. Reactivation from retirement applications containing malpractice or legal issues will require more time to process.

Reactivation from retirement licenses recommended for revival by the Licensing Committee are forwarded to the Board for approval at its next meeting, approximately two weeks later. Upon approval of your application for licensure, your wallet-sized card will be mailed to you.

CONTROLLED LICENSE SUBSTANCE REGISTRATION AND DEA REGISTRATION

If you wish to prescribe or dispense drugs, you must apply for a Massachusetts Controlled Substance Registration. Go to the Department of Public Health website at www.mass.gov/dph/dcp for an application for Massachusetts Controlled Substance Registration and follow the instructions or call (617) 753-8052. For DEA registration, go to the DEA website at www.deadiversion.usdoj.gov and follow the instructions or call (617) 557-2468.

ADDRESS CHANGES

The Board's regulations require that you notify the Board, within 30 days, in writing, when any of your addresses change. Please note that only one address can be a post office box and it cannot be your mailing address.

BIRTH DATE RENEWAL

Renewal of your medical license will occur on your first birthday after the license issuance date, unless your birthday falls within ninety (90) days of obtaining initial licensure. If your first birthday after the issuance date falls within this time frame, you will not be required to renew your license until the following birthday. Renewals thereafter will be on a two-year birthday cycle.

Please be advised that under Massachusetts law you may not practice medicine in Massachusetts until you have received a license. The license applicant is responsible for determining that the Board has issued a license prior to practicing medicine in the Commonwealth of Massachusetts.

PLEASE MAKE A COPY OF ALL SUBMITTED FORMS FOR YOUR RECORDS.

Please include the National Practitioner Data Bank Profile and malpractice history reports or any other documents with your reactivation from retirement application and mail them to the Board. The Board's regulations require that you provide a copy of your completed reactivation from retirement application and supplement to all healthcare affiliations.

TELEPHONE DIRECTORY AND WEBSITE ADDRESSES

- American Medical Association..... (800) 621-8335
www.ama-assn.org
- Board of Registration in Medicine..... (781) 876-8200
www.mass.gov/massmedboard
- Education Commission for Foreign Medical Graduates (ECFMG) (215) 386-5900
www.ecfmg.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) 753-8052
- 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-hipdb.com

3.19.14

REACTIVATION FROM RETIREMENT **APPLICATION CHECKLIST**

Before sending your Reactivation from Retirement Application to the Board for processing, please refer to this checklist to insure that you have provided all required documentation; otherwise, your license may be delayed.

HAVE YOU

- Downloaded and included all pages of the license application?
- Enclosed a check in the amount of \$600.00 made payable to the Commonwealth of Massachusetts?
- Read the instructions, answered every question, signed the application and Authorization for Release of Information?
- Completed and enclosed the Supplement form if you answered "yes" to any question on the Supplement?
- Completed and enclosed the original Malpractice History form listing liability carriers since postgraduate training with dates of coverage and policy numbers.
- Enclosed malpractice history reports from all liability carriers since postgraduate training listed on your Malpractice History form.
- Enclosed malpractice claim report(s) or letter of intent for open or closed malpractice cases from the attorney or liability carrier(s) in sealed envelopes.
- Downloaded the National Practitioner Data Bank (NPDB) Self Query form from the NPDB website at www.npdb.com and followed the instructions for a self query? Please note that the Data Bank form must be signed in the presence of a notary public and notarized before mailing.
- Followed the instructions for requesting the American Medical Association (AMA) Profile from the website at www.ama-assn.org. The AMA Profile will be mailed directly to the Board.
- Included the unopened Data Bank profile, malpractice history information or any other legal documents in the envelope with your Reactivation from Retirement application before mailing it to the Board?

IF THE SEAL ON THE DATA BANK PROFILE ENVELOPE IS OPENED, IT WILL NOT BE ACCEPTED BY THE BOARD.

APPLICANT'S NAME: _____

Hospital Affiliations and Employment

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____		State: _____
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____		State: _____
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____		State: _____
Facility: _____	Position: _____	____/____/____	____/____/____
Street: _____	City: _____		State: _____

Continuing Medical Education Credits

Read instructions for continuing medical education requirements before completing.

Category 1 credits _____ Risk Management Category 1 _____

Category 2 credits _____ Risk Management Category 2 _____

Continuing medical education credit requirements must be completed before the license is reactivated. (See Reactivation from Retirement Application Instructions.)

1. List other states (abbreviations) where you are currently or have ever been licensed: _____
2. Are you certified by the American Board of Medical Specialties (ABMS)? Yes No
3. List only ABMS certification(s): _____

4. Reason for seeking reactivation from retirement _____

5. Practice plan: _____
(Attach a separate sheet of paper if necessary.)
6. Attach your current curriculum vitae.

APPLICANT'S NAME: _____

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 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.

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

Signature: _____ Date: ____/____/____

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING, FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES.

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/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)

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

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return it with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, _____,
(type or print name)

certify, under the penalties of perjury, to the best of my knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: _____ DATE: _____

Social Security Number: _____

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.07 (15) require that you complete the following statement:

I will not charge to, or collect from, a Medicare beneficiary more than the Medicare “reasonable charge” for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: _____

REACTIVATION FROM RETIREMENT APPLICATION SUPPLEMENT

PRINT NAME: _____ DATE: ____/____/____

IMPORTANT NOTE: If you answer “yes” to any of these questions, you must provide the additional information on pages 5-11.

<u>QUESTIONS</u>	<u>YES</u>	<u>NO</u>
1. While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)	<input type="checkbox"/>	<input type="checkbox"/>
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?	<input type="checkbox"/>	<input type="checkbox"/>
2-B. Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?	<input type="checkbox"/>	<input type="checkbox"/>
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?	<input type="checkbox"/>	<input type="checkbox"/>
4. Since your enrollment in college, 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?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever 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.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?	<input type="checkbox"/>	<input type="checkbox"/>
8-A. Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?	<input type="checkbox"/>	<input type="checkbox"/>
8-B. Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)	<input type="checkbox"/>	<input type="checkbox"/>

- | | | <u>YES</u> | <u>NO</u> |
|-------|--|--------------------------|--------------------------|
| 9-A. | Have you ever relinquished any medical staff membership or association with a health care facility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9-B. | Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9-C. | Have you ever withdrawn an application for hospital privileges or appointment, or have you ever 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | Has your privilege to manufacture, distribute, administer, 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"/> |
| 12. | Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14-A. | Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14-B. | Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved? | <input type="checkbox"/> | <input type="checkbox"/> |

CONFIDENTIAL INFORMATION

If answering “yes” to any of the questions, provide details on the supplemental pages for questions 15-17. 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 impact one’s functioning as a physician.

- | | | <u>YES</u> | <u>NO</u> |
|-----|---|--------------------------|--------------------------|
| 15. | Do you have a medical or physical condition that currently impairs your ability to practice medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. | 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"/> |
| 17. | Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances? | <input type="checkbox"/> | <input type="checkbox"/> |

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.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

PRINT NAME: _____ DATE: ____/____/____

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare “reasonable charge” for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury 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 G.L.c. 62C, § 49A, 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. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board’s regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

SIGNATURE: _____ DATE: ____/____/____

PRINT NAME: _____ DATE: ____/____/____

For all questions, please attach additional pages, whenever necessary, using the same format.

QUESTIONS #1, 8A, 8B – Disciplinary action.

Name of agency or institution taking action: _____ Date: ____/____/____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to any disciplinary action. Documents should be sent directly to you in a sealed envelope.

QUESTION #2-A or 2-B – Medical school or any postgraduate training termination, leave of absence, withdrawal, repeating a year of training, probation, or remediation.

Name of institution: _____ Date: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any leave of absence, withdrawal, failure to complete, requirement to repeat, termination, probation, or remediation. Documents should be sent directly to you in a sealed envelope.

QUESTION #3 – Medical school more than 4 years for U.S. or Canadian graduates or more than 6 years for international medical graduates.

Name of institution: _____ Date: ____/____/____

State or Country: _____ Dates of attendance: From: ____/____/____ To: ____/____/____

Explanation: _____

PRINT NAME: _____ DATE: ____/____/____

QUESTION #4 – Examination denial; improper conduct.

Name of organization: _____ Name of exam: _____

Action: _____ Date: ____/____/____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any examination denial or improper conduct. Documents should be sent directly to you in a sealed envelope.

QUESTIONS #5 & 6 – Medical license application denial or withdrawal; license surrender or revocation.

Describe circumstances under which license application was withdrawn or denied, or license was surrendered or revoked.

State: _____ Year: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any medical application denial or withdrawal and any license surrender or revocation. The documents must specify the reason(s) and should be sent directly to you in a sealed envelope.

QUESTION #7 – ABMS or AOA certification denial, suspension, or revocation.

Specialty Board: _____ Date: ____/____/____

Explain reason(s) for loss or denial: _____

Please contact the certifying board to provide a letter explaining the reason(s) for the denial, suspension, or revocation. The letter should be sent directly to you in a sealed envelope.

PRINT NAME: _____ DATE: ____/____/____

QUESTIONS #9-A, 9-B, 9-C – Medical staff membership, status, privileges or association with a health care facility.

Name of facility: _____ Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Description: _____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 9-A through 9-C. Documents should be sent directly to you in a sealed envelope.

QUESTION #10 – Criminal Offenses.

Court: _____ Charge(s): _____ Date: ____/____/____

Describe the circumstances leading up to criminal proceedings. _____

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the indictment, complaint, judgment or other disposition in any criminal proceeding in which you were a defendant. Documents should be sent directly to you in a sealed envelope.

QUESTION #11 – Controlled substances privileges.

Type of restriction: _____ Date: ____/____/____

Describe the circumstances of restriction: _____

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact, and correspondence related to any suspension, revocation, denial, restriction or surrender of controlled substance privileges. Documents should be sent directly to you in a sealed envelope.

PRINT NAME: _____ DATE: ____/____/____

QUESTIONS #12 &13– Liability insurance provider, third party payor, Medicare and Medicaid (any state).

Name of Organization: _____ Date of action: ____/____/____

Action: _____

Describe reason(s) for action: _____

You must arrange for your liability carrier or appropriate institution or agency to submit documents regarding any restrictions, denials, or revocations. Documents should be sent directly to you in a sealed envelope.

PRINT NAME: _____ DATE: ____/____/____

QUESTION #14-A – Malpractice claims.

For each instance of alleged malpractice, you must provide the following information.

Claimant's name: _____ Date of incident: ____/____/____

Insurer's name: _____

Insurer's Address: _____

Description of claim (allegations only: this does not constitute an admission of fault or liability).

Allegation: _____ Allegation: _____ Allegation: _____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient's condition at point of your involvement: _____

2. Patient's condition at end of treatment: _____

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

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

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

6. Legal representative's name: _____

Address: _____ Telephone: _____

City: _____ State: _____ Zip: _____

(Question #14-A continued on next page)

PRINT NAME: _____ DATE: ____/____/____

QUESTION #14-A (continued)

Current status of claim: Closed Pending

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

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

Decision determined by: Judge Jury

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

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

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

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

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

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

QUESTION #14-B – Civil lawsuits (other than medical malpractice).

Plaintiff's name: _____ Date: ____/____/____

Your legal representative's name: _____

Description of claim (this does not constitute admission or liability): _____

Outcome of lawsuit: _____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #15 – Medical condition.

If you answered “yes” to Question 15, 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 #16 – 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 #17 - Refusal to take a screening test for chemical substances.

If you answered “yes” to Question 17, please provide a description of the circumstances leading to your refusal to take the screening test and any resulting criminal or disciplinary consequences.

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

MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of your current and all past liability carrier(s). You must provide your malpractice history reports if you ever had a full license in any state. You do not need to supply your malpractice history reports while participating in an ACGME postgraduate training program unless you had a full license or you were named in a malpractice case. This form must be returned to the Board with your license application.

Please provide the following information on the malpractice history report:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: Please report any open or closed cases that have gone to trial, whether or not monies were paid, and provide a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant. If the applicant does not have any claims history, please indicate that on your letterhead. If your company's name has changed, please provide any former company names. The information should be sent to the applicant.

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____/____ To: ____/____/____
City: _____ State: _____ Policy #: _____

Applicant's signature: _____ /____/____
Date

Print Name: _____

Address: _____

City: _____ State: _____ Zip code: _____