

**MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
PROFESSIONAL ORGANIZATION DISCIPLINARY ACTION INITIAL REPORT**

This report must be filed within 30 days of the imposition of a disciplinary action.

For further information, please refer to Instructions. Please type or print legibly.

Physician/Provider Information

Name: _____

License number: _____

Professional Organization Information

Organization name: _____

Telephone: _____

Report Completed by: _____ Title: _____

Action Taken

1. Date of disciplinary action: _____ 2. Date report completed: _____

3. Term(s) of disciplinary action are currently (*circle one*): a. Fulfilled b. Continuing

4. Expected or actual total duration of disciplinary action is (*circle one*):

- | | |
|--------------------------|-------------------------|
| 1. Less than 30 days | 2. Between 30 – 90 days |
| 3. Between 91 - 180 days | 4. More than 180 days |
| 5. Permanent | 6. Pending |
| 7. Other | |

5. Nature of action(s) taken (*circle each that applies*):

- | | | |
|-----------------------------------|---|--|
| 01 Revocation of right/privilege | 06 Non-renewal of right/privilege | 12 Leave of absence |
| 02 Suspension of right/privilege | 09 Education/training/counseling/monitoring | 13 Withdrawal of application |
| 03 Censure | 10 Denial of right/privilege | 14 Termination/non-renewal of contract |
| 04 Written reprimand/admonition | 11 Resignation | 98 Other (explain below) |
| 05 Restriction of right/privilege | | |

6. Please provide a brief narrative description of the action(s) taken. Where applicable, specify whether the action was voluntary or involuntary.

Substantiating Information

Please provide a detailed explanation of the event(s) or behavior that led to the disciplinary action(s). If applicable, include patient information, severity and type of injury, incident date and location. If more than one incident gave rise to the disciplinary action, or if more than one patient was involved, attach additional pages as necessary.

Patient Name: _____ Sex (M/F) ___ Date of Birth: ___ ___/___ ___/___ ___
 Date of Incident: ___ ___ / ___ ___ / ___ ___ (to ___ ___ / ___ ___ / ___ ___)

Location (*circle one*):

- | | | | |
|-----------------------------|-------------------|-----------------|-----------------------|
| 01 Emergency Room | 05 Outpatient | 09 HMO | 12 Physician's Office |
| 02 Labor/Delivery | 06 Patient Room | 10 Clinic | 13 Walk-In Center |
| 03 Laboratory/X-Ray/Testing | 07 Hospital-Other | 11 Nursing Home | 14 Other: _____ |
| 04 Operating Room | 16 ICU | | |

Basis Code(s): Please refer to the attached List of Basis Codes and provide those which best characterize the reasons for the action taken:

Basis Code: ___ ___ Basis Code: ___ ___ Basis Code: ___ ___ Basis Code: ___ ___ Basis Code: ___ ___

Brief Description of incident, or Reasons for Taking Action:

Any questions concerning the proper completion of this form should be directed to the Data Repository Counsel at (781) 876-8200. Completed forms should be mailed to the Data Repository Counsel, Board of Registration in Medicine, 200 Harvard Mill Square, Suite 330, Wakefield, MA 01880.