

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

**CHANGE OF PROGRAM APPLICATION**

**IMPORTANT:** Please read accompanying instructions before completing the application and print legibly. Sections A and C must be completed by the applicant. Attach check for \$100.00 made payable to Commonwealth of Massachusetts.

**SECTION A: To be completed by applicant.**

1. Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_
2. Mailing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Name of Medical School: \_\_\_\_\_ Year Graduated: \_\_\_\_\_
4. Name of Training Program: \_\_\_\_\_
5. Current Limited License Number: \_\_\_\_\_

**5-A Previous Training Programs:** List previous license numbers, training institutions and programs

<u>License #</u>	<u>Training Program Name</u>	<u>City and State</u>	<u>From</u>	<u>To</u>
_____	_____	_____	____/____	____/____
_____	_____	_____	____/____	____/____

**Other State Licenses:** List states (abbreviations) where you are currently licensed to practice medicine (include residency training licenses). Indicate whether full license, residency or limited license.

\_\_\_\_\_  (Full) \_\_\_\_\_  (Full) \_\_\_\_\_  (Full ) \_\_\_\_\_  (Limited) \_\_\_\_\_  (Limited)

- 5-B. Was your previous training a prerequisite for entering this program? YES  NO
- 5-C. Did you complete your previous training program(s)? YES  NO

If you answered "no" to 5-B or 5-C, attach an explanation. The program director must provide a letter certifying the circumstances under which you left the training program and complete the enclosed evaluation form. The letter and evaluation form must be placed in an envelope by the program director and sealed and signed across the seal. Please note that if the seal on the envelope is broken the documents will not be accepted.

**THIS SECTION MUST BE COMPLETED BY THE CURRENT PROGRAM DIRECTOR**

Is the above named physician in good standing in the Residency/Fellowship program? YES  NO

Has the physician been subject to any past or pending disciplinary action in this program? YES  NO

Type or Print Name and Title \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Program Director \_\_\_\_\_ Telephone: \_\_\_\_\_

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL AT THE FACILITY WHERE THE APPLICANT WILL BE TRAINING.**

This certifies that \_\_\_\_\_ has been appointed to the

position of  Intern  Resident  Fellow

in the specialty of \_\_\_\_\_ as a PGY \_\_\_\_\_

Department: \_\_\_\_\_ Subspecialty: \_\_\_\_\_

at \_\_\_\_\_

(Name of Healthcare Facility)

beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ to anticipated completion of training: \_\_\_\_/\_\_\_\_/\_\_\_\_.  
Month Day Year Month Day Year

**YES** **NO**

Is the training program listed above ACGME accredited?

If no is there an approved ACGME program in applicant's specialty?

Designated Official's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Type or Print Name: \_\_\_\_\_

Official Title: \_\_\_\_\_ Telephone \_\_\_\_\_

**SECTION C ON PAGE 3 TO BE COMPLETED BY APPLICANT**

**SECTION C: Please read the instructions before answering the questions below. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.**

**NOTE: These questions refer to the period since you signed your last limited renewal**

	<u>YES</u>	<u>NO</u>
16-A. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?	<input type="checkbox"/>	<input type="checkbox"/>
16-B. Have you, for any reason, been placed on probation in any postgraduate training program?	<input type="checkbox"/>	<input type="checkbox"/>
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?	<input type="checkbox"/>	<input type="checkbox"/>
18. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you voluntarily surrendered a license to practice medicine or any healing art?	<input type="checkbox"/>	<input type="checkbox"/>
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).	<input type="checkbox"/>	<input type="checkbox"/>
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).	<input type="checkbox"/>	<input type="checkbox"/>
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?	<input type="checkbox"/>	<input type="checkbox"/>
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have you voluntarily relinquished medical staff membership?	<input type="checkbox"/>	<input type="checkbox"/>
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?	<input type="checkbox"/>	<input type="checkbox"/>
26. Have you been charged with any criminal offense, other than a minor traffic offense?	<input type="checkbox"/>	<input type="checkbox"/>
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?	<input type="checkbox"/>	<input type="checkbox"/>
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	<input type="checkbox"/>	<input type="checkbox"/>
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?	<input type="checkbox"/>	<input type="checkbox"/>

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**CONFIDENTIAL MEDICAL INFORMATION**

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

**NOTE:** *These questions refer to the period since you signed your last limited renewal.*

- |   | <u>YES</u>               | <u>NO</u>                |
|---|--------------------------|--------------------------|
| 30. Have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician? | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Do you currently have a medical condition which limits or impairs your ability to practice medicine or to function as a physician?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?  | <input type="checkbox"/> | <input type="checkbox"/> |

If your responses to Questions 16-35 change while your application is pending, you must notify the Board of the new information immediately.

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**CERTIFICATIONS**

I certify that I have complied with my obligations to report abuse of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A ½.

I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.

I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.

I will read the Board’s regulations, 243 CMR 1.00 through 3.00.

Under the penalties of perjury, I declare that I have examined this change of program 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. As an applicant for a limited license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to “moonlight” under any circumstances.**