

# FORM R

Commonwealth of Massachusetts Board of Registration in Medicine  
560 Harrison Avenue, Suite G-4, Boston, Massachusetts 02118 - www.massmedboard.org

## Physician Registration Renewal Form R

**Additional information related to questions 14, 15 and 16.** If you answered "Yes" to any of these questions, provide the following information where applicable, even if you have previously provided some or all of this information to the Board. Attach additional sheets (with same format) where necessary.

Sections A, B, and C must be completely and accurately filled out for each claim reported. Section D must be filled out only if the case was appealed.

*The renewal application will be returned to you if there are any unanswered questions or missing documentation on the Form R. This will delay the renewal of your license.*

### **SECTION A:**

Physician Name: \_\_\_\_\_ License No.: \_\_\_\_\_

Insurer (at the time of incident): \_\_\_\_\_ Policy No.: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Claimant Name, if different from patient: \_\_\_\_\_

Incident Date: \_\_\_\_/\_\_\_\_/\_\_\_\_(mm/dd/yyyy) All fields required.

**Description of claims.** This does not constitute an admission of fault or liability. (Please note: use the Renewal Instructions, Reference Table 5, page 19 for a list of allegations. )

Allegation: \_\_\_\_\_ Allegation: \_\_\_\_\_ Allegation: \_\_\_\_\_

Narrative:  
\_\_\_\_\_  
\_\_\_\_\_

### **Incident Location (Circle only one.):**

Emergency Room	Outpatient	HMO	Physician's Office
Labor/Delivery	Patient Room	Clinic	Walk-in Center
Laboratory/X-Ray/Testing	ICU	Nursing Home	Other: _____
Operating Room	Hospital – other		

### **Your Role (Circle only one.):**

Attending Physician	Referring Physician	PGY 1	Fellow
Primary Care Physician	Anesthesiologist	PGY 2	Admin/Supervisor
Surgeon	On-Call Physician	PGY 3	Other: _____
Consultant Specialist	Group Practitioner/Partner	PGY 4	

### **SECTION B: THIS SECTION MUST BE COMPLETED FOR EVERY CLAIM**

Has this claim been filed with the Medical Malpractice Tribunal?  YES  NO

Has a decision been issued by the Tribunal?  YES  NO

Date of tribunal decision: \_\_\_\_/\_\_\_\_/\_\_\_\_(mm/dd/yyyy) All fields required.

Finding for:  YOU  PLAINTIFF  POSTED BOND

**YOU MUST SIGN AND DATE PAGE 2 OF THIS FORM**

**SECTION C:**

*For assistance with this section, please contact your medical liability insurance carrier or attorney prior to submitting the Form R.*

Docket Number: \_\_\_\_\_ Case Name (Plaintiffs and Defendants): \_\_\_\_\_

Venue (circle only one):

Barnstable    Bristol    Essex    Hampden    Middlesex    Norfolk    Suffolk  
Berkshire    Dukes    Franklin    Hampshire    Nantucket    Plymouth    Worcester  
Out of State: \_\_\_\_\_ Federal: \_\_\_\_\_

Current status of claim:     OPEN     CLOSED     PENDING

Was the case dismissed against you?     YES     NO Reason for dismissal: \_\_\_\_\_

Against all defendants?     YES     NO

What was the decision?     DEFENSE VERDICT     PLAINTIFF VERDICT  
 SETTLEMENT (Out of Court)     OTHER: (Specify) \_\_\_\_\_

Date of decision: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) All fields required.

Decision determined by:     JUDGE     JURY

If there was a payment made, indicate the following:

Total payment amount: \$ \_\_\_\_\_

Amount allocated to you: \$ \_\_\_\_\_

Date of payment: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) All fields required.

**NOTE: If there was a payment, but no monies were paid on your behalf, please indicate above.**

**If the case was appealed, please complete Section D.**

**SECTION D:**

If your case was appealed, indicate the following:

Date appeal filed: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) All fields required.

Court: \_\_\_\_\_

Outcome: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (mm/dd/yyyy) All fields required.

***Signature, date and license number required***

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

Print Name: \_\_\_\_\_ License No: \_\_\_\_\_

**Continued on Page 3 for Questions #17 - 21**

**Additional information related to QUESTIONS # 17 through 21.** If you answered "Yes" to any of these questions, provide the following information, even if you have previously provided some or all of this information to the Board. Attach additional sheets (with same format) where necessary.

**17. Criminal Proceedings:** Attach a copy of the following: 1) a copy of the indictment or complaint; 2) an up-to-date court docket sheet; and 3) all police reports.

Court: \_\_\_\_\_ Date of Incident: \_\_\_\_/\_\_\_\_/\_\_\_\_

Charge(s): \_\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

Status: \_\_\_\_\_

**18. Disciplinary Action**

Name of Organization: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Duration: \_\_\_\_\_

Action Taken or Pending (circle all that apply):

- |                                   |  |                             |
|-----------------------------------|--|-----------------------------|
| Revocation of right or privilege  | Required performance of public service   | Probation                   |
| Suspension of right or privilege  | Education/Training/Counseling/Monitoring | Assurance of Discontinuance |
| Censure                           | Denial of right or privilege             | Consent Order or Agreement  |
| Written reprimand or admonition   | Resignation                              | Monitoring Agreement        |
| Restriction of right or privilege | Leave of absence                         | Expulsion from Membership   |
| Non-renewal of right or privilege | Withdrawal of an application             | Other: _____                |
| Fine                              | Termination or non-renewal of contract   |                             |

Reason(s) for action (*See Renewal Instructions, Table 5, Page 19*): Allegation: \_\_\_\_\_ Allegation: \_\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**19. Restriction of Privileges to Prescribe Controlled Substances**

Type of Restriction: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

**20. Withdrawal or Denial of License**

State: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

**21. Liability Insurance Action**

Name of Organization: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Duration: \_\_\_\_\_

Description: \_\_\_\_\_

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Print Name:** \_\_\_\_\_ **License No :** \_\_\_\_\_

**YOU MUST SIGN AND DATE THIS FORM IF YOU ANSWER "YES" TO QUESTIONS #17 – 21.**