

APPLICANT'S NAME: _____

Postgraduate Education:

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

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

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. Do not include postgraduate training facilities. 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: _____	
Facility: _____	Position: _____	___/___/___	___/___/___
Street: _____	City: _____	State: _____	

APPLICANT'S NAME: _____

Medical Malpractice Information:

My medical malpractice insurance coverage is by: Insurance carrier Letter of Credit

Print name of insurer: _____

Policy dates: From: _____ To: _____

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because:

I am not involved in direct patient care Otherwise exempt

Explain exemption _____

Continuing Medical Education Credits

Read instructions for continuing medical education requirements before completing.

Activity status: Active Exemption _____

Category 1 credits _____

Risk Management Category 1 _____

Category 2 credits _____

Risk Management Category 2 _____

Continuing medical education credit requirements must be completed before the lapsed license can be revived if you are applying for active license status. (See Lapsed License 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 requesting revival of lapsed license in Massachusetts: _____

5. Please attach your current curriculum vitae

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as “health care providers” in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is:

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: ____/____/____

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.

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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 pains and penalties of perjury, I declare that I have examined this Lapsed License Application and all of 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 revival of a lapsed 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: ____/____/____

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

Revised: 10.05.09