

MA License Number: _____
Date license revived: ____/____/____

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

LAPSED LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of \$600.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

Activity Status: Active Inactive*

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Medical Degree: M.D. D.O. Ph.D. Other degree _____

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ____/____/____ Social Security Number: ____ - ____ - ____
Month Day Year

Place of Birth: _____
City State/Province/Territory Country if not USA

Home Address: _____
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Address: _____
Number and Street

City State/Province/Territory Zip (or postal) Code

Business Home Telephone: (____) _____, ext. _____ Telephone: (____) _____

E-mail Address _____ Fax Number: _____

Preferred Mailing Address: Business Address Home Address

***Inactive status:** If you check inactive status when you sign the lapsed application, you certify that you will not practice medicine in Massachusetts.

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

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 Inactive 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 reviving Lapsed License in Massachusetts: _____

5. Please attach your current curriculum vitae

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 lapsed 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 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.

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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 the purposes of conducting these business transactions. Under the HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order to complete your license application must take one of the following actions:

- Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPEs web site at www.NPPEs.cms.hhs.gov.
- Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
- Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number you must notify the Board (see instructions for Option 2).
- Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Check the appropriate box below, supply appropriate information, and sign the bottom of the page.

- My current NPI is:
- I have personally applied for an NPI.
- I have applied for an NPI using a third party (enter name) _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (See Lapsed License Instructions, pages 7, 8 and 9). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	<u>Taxonomy (Specialty) Code</u>	<u>Taxonomy Description (Print)</u>
Primary Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Provider Taxonomy:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: - -

State of Birth (if US): _____ Country of Birth (if outside the US): _____

Gender: Male Female

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.

Authorization for NPI Dissemination

Check one box: I authorize I do not authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan or health organization.

Signature: _____ Date: ____/____/____