

CHECKLIST FOR LAPSED LICENSE APPLICATION

Before sending your lapsed license application to the Board for processing, please refer to this checklist to insure that you have provided all required documentation; otherwise, your lapsed license may be delayed.

HAVE YOU

- Downloaded and included all pages of the lapsed license application?
- Enclosed a check in the amount of \$600.00 made payable to the Commonwealth of Massachusetts?
- Read the instructions, answered every question, signed the application and Authorization for Release of Information and enclosed a check for \$600.00 made payable to the Commonwealth of Massachusetts?
- Completed and enclosed the supplemental form if you answered "yes" to any question on the supplement?
- Completed and enclosed a copy of the malpractice history report if you answered "yes" to questions #10-A or 10-B and sent a copy to your liability carriers for the past ten (10) years?
- Downloaded the National Practitioner Data Bank (NPDB) Self Query form from the NPDB website at www.npdb.com and followed the instructions for a self query? Please note that the Data Bank form must be signed in the presence of a notary public and notarized before mailing.
- Followed the instructions for requesting the American Medical Association (AMA) Profile from the website at www.ama-assn.org. The AMA Profile will be mailed directly to the Board.
- Included the unopened Data Bank profile with your lapsed application before mailing it to the Board?

IF THE SEAL ON THE DATA BANK PROFILE ENVELOPE IS BROKEN, IT WILL NOT BE ACCEPTED BY THE BOARD.

Revised: 10/07/2002

COMMONWEALTH OF MASSACHUSETTS--BOARD OF REGISTRATION IN MEDICINE
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880 - www.massmedboard.org

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____
(type/print your complete name)

request and authorize every person, institution, professional licensing board of any state in which I hold or may have held a license to practice my profession, hospital, clinic, government agency, (local, state, federal or foreign), law enforcement agency, or other third parties and organizations, and their representatives to release information, records, transcripts, and other documents, concerning my professional qualifications and competency, ethics, character, and other information pertaining to me to the Massachusetts Board of Registration in Medicine.

I further request and authorize that the requested information, documents and records be sent directly to:

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Attention: Licensing

Immunity and Release

I hereby extend absolute immunity to, and release, discharge, and hold harmless from any and all liability: 1) the Board of Registration in Medicine, its agents, representatives, directors and officers; 2) other agencies, institutions, hospitals and clinics providing information, their representatives, directors and officers; and 3) any third parties and organizations for any acts, communications, reports, records, transcripts, statements, documents, recommendations or disclosures involving me, made in good faith and without malice, requested or received by the Board of Registration in Medicine.

By my signature below, I acknowledge that information, documents and records required to be furnished by another organization, educational institution, hospital, individual or any person or groups of persons has been sent to me directly from the primary source in a sealed envelope and that none of the seals have been broken. I understand that the Board of Registration in Medicine will not accept any such information, records or documents forwarded by me unless they are in sealed envelopes.

A photocopy or facsimile of this authorization shall be as valid as the original and shall be valid up to one year from the date signed.

Applicant's Signature

Date of Signature

Applicant's Printed Last Name, First Name, Middle Initial, Suffix (e.g., Jr.)

Applicant's Date of Birth (month/day/year)

American Medical Association

Physicians dedicated to the health of America

Telephone: 800-621-8335

Fax: 312 464-5900

AMA Physician Profile Order Form -- Physician Use Only

Complete and send this form to the American Medical Association (AMA). Profiles also can be ordered online through **AMA Physician Profiles** located at <http://www.ama-assn.org/go/AMAProfiles>. AMA Customer Service is available for ordering assistance at 800-621-8335, 24 hours a day, seven days a week.

*****Join or renew your AMA membership today---call 800-AMA-3211*****

Standard Mail Service (within 10 business days)

Indicate AMA Membership Status:

_____ Member Physician	No charge
_____ Nonmember Physician	\$33 per profile

**Prices are subject to change without advance notice.*

Credit card payment is accepted. Checks should be made payable to the American Medical Association, 75 Remittance Drive Suite #6397, Chicago IL 60675-6397. Orders faxed to the AMA must include credit card information for billing purposes.

___ VISA ___ American Express ___ MasterCard Charge Amount: \$ _____

Credit Card Number _____ Expiration Date: ___/___/___

Name on Credit Card: _____

Billing Address: _____

Approval Signature _____ Daytime Telephone: _____

Part 1: AMA Physician Profile Delivery Information

Please send my profile to the following state licensing board:

Board Name: _____

NOTE: When requesting delivery to a state licensing board, indicate MD or DO profession type.

Part 2: Physician Information

Physician Name (first, middle, last, suffix) _____

Place of Birth _____ / / _____ Social Security Number _____

E-mail Address _____ Medical Education Number (optional) _____

Preferred Mailing Address _____

City, State, Zip Code _____ (____) _____ - _____ Telephone Number _____

The above address is my OFFICE ___ HOME ___ OTHER ___

If address is home or other, please complete this section.

Primary Office Address _____

City _____ State _____ Zip Code _____ Office Telephone Number _____

Part 3: Medical Education and Other Information

Medical School of Graduation

Year of Graduation

DEA Number

ECFMG Number

Residency Training

Residency Training (institution/hospital name, location, and years)

Hospital Admitting Privileges

Hospital Name

City/State

Group Practice Affiliation(s)

Group Practice Name

City/State

Physician Agreement

Agreement must be signed in order to process your request.

AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of fee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

X _____
Signature

_____/_____/_____
Date

MEDICARE TAX FORM

**Commonwealth of Massachusetts--Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880**

MEDICARE/TAX FORM

INSTRUCTIONS:

Please sign this form and return with your application. Massachusetts General Laws Chapter 62C, §49A, requires that you complete this statement to obtain licensure to practice a profession:

I, _____,
(type or print name)

certify, under the penalties of perjury, to my best knowledge and belief, that I have filed all state tax returns and paid all state taxes required by state law.

SIGNED: _____ DATE: _____

Social Security Number: _____

Massachusetts General Laws Chapter 112, §2, and 243 CMR 2.04 (2) (k) require that you complete the following statement:

I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985.

Note: Signing this form does not imply that you will participate in the Medicare program.

SIGNED: _____ DATE: _____