Change of Program Checklist

- Answered all Questions
    - Remember that each question refers only to the period since you signed and submitted your last Mass limited license application
- Printed name on top of each page of application
- Signed and dated Pg5 of Application
- Signed and dated Authorization for Release
- Completed supplemental page for any questions marked "yes"
- Evaluation Form completed by most recent Program Director
    - If applicable, include one from your last MA Program Director as well
- Attached CV in Month/Year format
    - No timeline gaps and must be in chronological order
- Included License Verifications for any state in which you held a Full License since you signed and submitted your last Mass limited license application.

The $100.00 application fee will be paid by Boston Medical Center for all paid employees.

PLEASE NOTE: The Program Director signature on Page 1 refers to your most recent MASSACHUSETTS Program Director. *No Program Director from outside Massachusetts should sign this portion*

If you have questions regarding your application contact your Program Coordinator, DO NOT contact the Board of Registration in Medicine under any circumstances.

Completed license packets are to be sent directly to your Program Coordinator, DO NOT send materials directly to the Board of Registration in Medicine.

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Website: www.mass.gov/massmedboard

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: Boston Medical Center
5. Current Limited License Number: _____

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

License #	Training Program Name	City and State	From	To
_____	_____	_____	___/___	___/____
_____	_____	_____	___/___	___/____

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 Boston Medical Center
(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: Jeffrey Schneider, MD

Official Title: Designated Institution Official Telephone 617-414-7144

SECTION C ON PAGE 3 TO BE COMPLETED BY APPLICANT

SECTION C: Read the instructions. 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

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEWAL

		YES	NO
6-A.	Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?	☐	☐
6-B.	Have you, for any reason, been placed on probation in any postgraduate training program?	☐	☐
7.	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?	☐	☐
8.	Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?	☐	☐
9.	Have you voluntarily surrendered a license to practice medicine or any healing art?	☐	☐
10.	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).	☐	☐
11.	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).	☐	☐
12.	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?	☐	☐
13.	Have you, for any reason, withdrawn an application for hospital privileges or appointment?	☐	☐
14.	Have you voluntarily relinquished medical staff membership?	☐	☐
15.	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?	☐	☐
16.	Have you been charged with any criminal offense, other than a minor traffic offense?	☐	☐
17.	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?	☐	☐
18.	Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?	☐	☐
19.	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?	☐	☐

(Continued on page 3)

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.

THESE QUESTIONS REFER TO THE PERIOD SINCE YOU SIGNED YOUR LAST LIMITED RENEW

		YES	NO
20.	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?	☐	☐
21.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?	☐	☐
22.	Have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?	☐	☐
23.	Have you refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?	☐	☐
24.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?	☐	☐
25.	Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?	☐	☐

If your responses to Questions 6-25 change while your application is pending, you must notify the Board of the new information immediately.

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.

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.

Revised: 12.18.2013

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, _____
(type or 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)

PRINT NAME: _____

QUESTIONS #6-A, 6-B & 7 – Postgraduate training program and examinations

Attach additional pages with same format where necessary.

Name of institution:_____Date of action:___/___/____

Address: _____ City:_____

State:_____Zip:_____ Dates of attendance: From: ____/____/____ To: ____/____/_____

Description of events: _____

_____

_____

_____

You must arrange for the appropriate agency or institution to submit all official documentation and correspondence regarding any probation, termination, leave of absence, withdrawal, failure to complete or requirement to repeat a postgraduate training program directly to the Board.

QUESTIONS #8 & 9 – License application withdrawal, denial or license surrender

Attach additional pages with same format where necessary.

Describe circumstances under which license application was withdrawn or denied, or license was voluntarily surrendered.

_____

_____

_____

_____

State: _____Year: ____/_____/_____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding the withdrawal, denial or voluntary surrender directly to the Board. Such documentation must specify the reason(s) for denial or withdrawal of your license application or voluntary surrender of your license application.

QUESTIONS #10 & 11 – Disciplinary actions

Attach additional pages with same format where more than one action was taken or is pending, and where otherwise necessary.

Name of agency or institution taking action:_____ Date: ____/___/___

Description:_____

_____

_____

_____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence related to the disciplinary action directly to the Board.

Signature: _____ Date: ____/____/____

PRINT NAME: _____

QUESTIONS #12, 13, 14 & 15 – Medical staff membership, status and/or privileges

Attach additional pages with same format where necessary. Describe circumstances leading to change in medical staff membership, status and privileges:

Name of facility:_____ Date of action :_____/____/____

Address:_____City: _____ State: _____Zip:_____

Description: _____

_____

_____

_____

You must arrange for the appropriate agency or institution to submit copies of all official documentation and correspondence regarding any affirmative responses to Questions 12, 13, 14 and 15 directly the Board.

QUESTION #16 – Criminal proceedings

Attach additional pages with same format if more than one charge and where otherwise necessary.

Court:_____Charge: _____Date: ____/____/____

Please attach a detailed account of circumstances leading up to criminal proceedings.

_____

_____

_____

Status: _____

You must arrange for your lawyer or the court officer to submit copies of the police report, indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant directly to the Board.

QUESTION #17 – Controlled substances privileges

Attach additional pages with same format where necessary.

Type of restriction:_____ Date: ____/____/____

Circumstances of restriction: _____

_____

_____

_____

You must arrange for the appropriate agency or institution to submit a copy of all official orders, findings of fact and correspondence related to any affirmative response directly to the Board.

Signature: _____ Date: ____/____/____

PRINT NAME: _____

QUESTIONS #18 & 19 – Malpractice claims and other lawsuits

You must provide the following information on this form for each instance of alleged malpractice. You may photocopy this form and attach additional copies, if necessary. You must also complete the back of this form. Please print legibly.

Claimant's name: _____ Date of incident: ___/____/____

Insurer's name:_____Insurer's address: _____

Description of alleged basis (es) of claim (allegations only: this does not constitute an admission of fault or liability). (See Basis for Allegation on page 7.)

Allegation _____ Allegation _____ Allegation _____

REQUISITE DESCRIPTIVE INFORMATION:

1. Patient's condition at point of your involvement:_____
_____
_____
_____

2. Patient's condition at end of treatment:_____
_____
_____
_____

3. The nature and extent of your involvement with the patient:_____
_____
_____
_____

4. Your degree of responsibility for the course of treatment leading to the claim: _____
_____
_____
_____

5. If incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:

_____

Incident location (check one):

- ☐ 01 Emergency Room
- ☐ 02 Labor/Delivery
- ☐ 03 Laboratory/X-ray/Testing
- ☐ 04 Operating Room
- ☐ 05 Outpatient
- ☐ 06 Patient Room
- ☐ 07 Hospital-Other
- ☐ 08 Hospital-Unknown
- ☐ 09 HMO
- ☐ 10 Clinic
- ☐ 11 Nursing Home
- ☐ 12 Physician's Office
- ☐ 13 Walk-in Center
- ☐ 14 Other
- ☐ 15 Unknown

Your role (check one):

- ☐ 01 Anesthesiologist
- ☐ 02 Primary Care Physician
- ☐ 03 Referring Physician
- ☐ 04 Attending Physician
- ☐ 05 Consultant Specialist
- ☐ 06 Surgeon
- ☐ 07 Fellow
- ☐ 08 PGY 7
- ☐ 09 PGY 6
- ☐ 10 PGY 5
- ☐ 11 PGY 4
- ☐ 12 PGY 3
- ☐ 13 PGY 2
- ☐ 14 PGY 1
- ☐ 22 Acupuncturist
- ☐ 26 On-call Physician
- ☐ 27 Worker's Comp Evaluator
- ☐ 28 Court Psychiatrist
- ☐ 24 Group Practitioner/Partner
- ☐ 99 Unknown
- ☐ 98 Other

(continued on next page)

QUESTION #18 & 19 - Malpractice claims & other lawsuits, continued…

Legal representative's name: _____

Address: _____Telephone: _____

City: _____ State: _____ Zip: _____

Current status of claim: ☐ Closed ☐ Pending

Was the case resolved before the entry of a verdict? ☐ Yes ☐ No

What was the decision? ☐ Dismissed before trial ☐ Plantiff Verdict ☐ Defense Verdict

Decision determined by: ☐ Judge ☐ Jury

If a payment was made: Amount allocated to you: $_____ Payment Date:_____/_____/_____

In addition to the information listed above, you must arrange for your lawyer or liability carrier to submit a copy of the following documents directly to the Board for the following malpractice cases:

Open case – a copy of the complaint naming the physician as a defendant.

Closed case – a copy of the complaint and final judgment, settlement and release or other final disposition of each claim, even if you were dismissed from the case by the court and/or if the case was closed with or without prejudice and the amount of monies paid on your behalf.

Dismissed case – a copy of the dismissal if you were dismissed before the case was reviewed by a tribunal or jury. The dismissal must include the name or initials of the patient and confirmation that no monies were paid on your behalf.

NOTE: Please be advised that the Board may request pertinent medical records or additional information.

Signature: _____ Date: ____/_____/____

PRINT NAME: _____

CONFIDENTIAL MEDICAL INFORMATION

QUESTION #20 & 21 – Medical condition

If you answered "yes" to Questions #20 or 21, please explain the specifics of your condition and any related treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your medical condition on your current practice, including a change of specialty or field of practice, or participation in any supervised rehabilitation program, professional assistance or retraining program, or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than three (3) months prior to the date of your application. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

_____

_____

_____

_____

_____

_____

_____

QUESTION #22 – Use of chemical substances

If you have obtained medical treatment related to your use of chemical substances, explain the specifics of your treatment, including dates and diagnoses. In addition, set forth any adjustments or interventions you may have made or taken to ameliorate or address the impact of your use of chemical substances on your current practice, including participation in any supervised rehabilitation program or monitoring program. You must arrange for your physician to send directly to the Board an evaluation of your current medical status, noting diagnosis, prognosis, treatment plan, and impact of condition on ability to practice medicine. This evaluation must be performed no more than thirty (30) days prior to the date of your application. You must also arrange for the appropriate institutions to submit all discharge summaries regarding any alcohol or drug dependency directly to the Board. At a later date, you may be asked to submit additional information, including documentation of compliance with any monitoring program.

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: ____/____/____

PRINT NAME: _____

QUESTION #23 – Refusal to take screening test

If you answered "yes" to Question #23, please set forth a description of the circumstances leading to the refusal to take the screening test and any resulting criminal or disciplinary consequences.

_____

_____

_____

_____

_____

QUESTION #24 – Illegal use or misuse of drugs

List chemical substances:

_____

_____

Describe frequency of usage: _____

_____

_____

_____

Please note that additional information may be requested by the Board.

QUESTION #25 – Voluntary modification of scope of practice

Describe circumstances leading to modification of practice: _____

_____

_____

_____

Describe modification of practice: _____

_____

_____

Dates: From: ____/____/____ To: _____/_____/_____

Please note that additional information may be requested by the Board.

Signature: _____ Date: ____/____/____

BASIS FOR ALLEGATION

ABUSE OF (PATIENTS, EMPLOYEE(S)/PEER(S
Abuse of Employee(s) /Peer(s) - Physical
Abuse of Patient(s) - Physical
Sexual misconduct
Sexual misconduct - Verbal

ADMINISTRATIVE PROBLEMS
Academic research fraud
Billing for services not rendered
Billing fraud (not Medicaid/Medicare)
Breach of confidentiality
False or deceptive advertising
Inadequate documentation/patient records
Insurance balance billing (not Medicaid/Medicare)
Medicaid/Medicare
Medicaid/Medicare balance billing

SUPERVISION
Fully licensed physician
Limited licensee (e.g. resident)
Nurse or other employee
Physician's assistant

DIAGNOSIS RELATED
Delay in diagnosis
Failure to Diagnose
Abdominal problems (not appendicitis or ulcer)
AIDS/AIDS Related Complex/HIV
Appendicitis
Bladder problem
Bone cancer
Bowel problem
Breast cancer
Cancer (unspecified)
Cardiac disorder (notmyocardial infarction)
Circulatory problem
Colon/rectal cancer
Diabetes
Eye disorder
Fracture/Dislocation
Gall Bladder disorder
Genetic disorder
Hemorrhage
Hernia
Hodgkin's disease
Implanted foreign body
Infection
Kidney disorder
Liver disorder
Liver/kidney/pancreas cancer
Lung cancer
Lyme disease
Meningitis
Myocardial infarction
Neurological disorder
Orthopedic problem (not fracture/dislocation)
Ovarian/cervical cancer
Pneumonia/pneumothorax
Respiratory problem
Skin cancer
Tendon injury
Testicular torsion
Testicular/prostate cancer
Tumor
Ulcer or complication(s) of ulcer
Failure to perform diagnostic test(s)
Lack of informed consent
Misdiagnosis
Ordering/performing unnecessary diagnostic tests/procedures

BIOMEDICAL EQUIPMENT/PRODUCT RELATED
Malfunction
Misuse

TREATMENT RELATED
Abandonment of patient
Delay in treatment
Failure to make referrals appropriately
Failure to monitor patient
Failure to notify patient of test results
Failure to take adequate patient history
Failure to treat
Failure to use consultants appropriately
Improper choice of treatment
Improper treatment of fracture/dislocation
Inappropriate admissions(s)
Inappropriate discharge(s)/transfer(s)
Lack of informed consent

Anesthesia Related
General
Allergic/adverse reaction
Failure to test improper use of equipment
Improper intubation
Improper positioning of patient
Lack of informed consent
Teeth damage
Wrong amount/type of anesthesia prescribed

Intravenous Related
CVP line
Dye reaction
General
Infiltration
Lack of informed consent

Medication Related
Drug side effect
Drug toxicity/overdose
Failure to diagnose drug addiction
Failure to diagnose drug related problem(s) (not addiction)
Failure to prescribe
General
Lack of informed consent
Prescribing to a known addict
Wrong dose of medication ordered/administered
Wrong medication ordered/administered

Mental Illness Related
Failure to diagnose mental disorder/illness/problem
Failure to warn third party(ies)
General
Improper commitment
Improper use of seclusion/restraints
Lack of informed consent
Suicide/suicide attempt by inpatient
Suicide/suicide attempt by outpatient

Obstetrics-Gynecology Related
Failed sterilization
Failure to diagnose ectopic pregnancy
Failure to diagnose Pregnancy, normal
Fetal death/stillbirth
Gynecology-general
Improper performance of abortion
Injury to child during labor/delivery
Injury to mother during labor/delivery
Lack of informed consent
Maternal death related to delivery
Obstetrics-general
Wrongful life/birth

Surgery Related
Delay in surgery
General
Failure to diagnose post-op complications
Improper treatment of post-op complication
Improper/negligent performance
Laceration/penetration not within scope of surgery
Lack of informed consent
Positioning-not anesthesia
Retained foreign bodies (e.g. needle, sponge)
Unnecessary surgery
Wrong body part or wrong patient

Specified Procedures/Specialties
Angiography/arteriography
Biopsy
CAT scan/MRI
Catheterization
Chemotherapy
Circumcision
Colonoscopy
Endoscopy
Injection/Immunization
Laparoscopy/laparotomy
Myelography
Neonatology
Neurology
Orthopedics
Pediatrics
Plastic/cosmetic surgery
Radiation therapy
Stress test
Suturing

TRANSFUSION RELATED
Caused AIDS/HIV
Caused hepatitis
Mismatch

MISCELLANEOUS
Improper utilization review
Improper Workmen's Compensation evaluation
Patient fall (in health carefacility/office)
Performance of autopsy without permission
Unauthorized DNR order
Vicarious liability for acts of another provider
Violation of patient's civil rights
Wrongful death of patient

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

SUPERVISORY EVALUATION FORM

APPLICANT INSTRUCTIONS:

- *This form must be completed by a supervising physician who can evaluate your clinical performance.*
- *At least one year of current evaluations are required. Locum tenens physicians must have evaluations from the most recent two years of assignments. The Board reserves the right to require additional Evaluation forms.*
- *Evaluation forms must be current within 120 days prior to Board review.*
- *The Evaluator must have no financial interest in your licensure in the State of Massachusetts.*

I hereby authorize the representatives or staff of the facility listed below to provide the *Board of Registration in Medicine* with any and all information requested in this evaluation form, whether such information is favorable or unfavorable, and I hereby release from any and all liability the named facility and/or any person for any and all acts performed in fulfilling this request, provided that such acts are performed in good faith and without malice.

Signature of applicant:_____ Date:_____/_____/_____

Please PRINT your name:_____

Name of Evaluating Hospital/Workplace:_____ State:____

SUPERVISING PHYSICIAN INSTRUCTIONS:

- Please complete items #1-10 below and return to the applicant with your name affixed across the envelope seal.
- The Board may provide a copy of this Form and any attachments to the applicant.

1. **Date(s) of applicant's affiliation at facility (month/year)?** From: _____/_____ To: _____/_____

2. **In what capacity did you supervise the applicant?** ☐ Department Chair ☐ Chief of Service ☐ Medical Director ☐ Training Director ☐ Supervising Physician ☐ Chief Medical Office

3. **Applicant's Status:** ☐ Intern ☐ Resident ☐ Fellow ☐ Staff Member ☐ Other _____

4. **Do you have any conflict of interest, personally, professionally or financially in recommending this applicant for licensure in Massachusetts?** ☐ YES ☐ NO

5. **Please rate the following (if "BELOW AVERAGE or "POOR", explain in detail on a separate sheet).**

	Superior	Above Average	Average	Below Average	Poor
Clinical knowledge					
Clinical competency					
Professional judgment					
Character and ethics					
Technical skills					
Relationships with staff					
Relationship with patients					
Cooperativeness/ability to work with others					

(Continued on page 2)

6. **Has the applicant's privileges to admit or treat patients ever been modified, suspended, reduced or revoked?** ☐YES ☐ NO (if "yes" please explain below)

_____

_____

7. **Has this applicant ever been the subject of disciplinary action or had staff privileges, employment or appointment at this hospital or facility voluntarily or involuntarily denied, suspended, revoked or has (s)he resigned from the medical staff in lieu of disciplinary action? If "yes" please explain below.** ☐ YES ☐ NO

_____

_____

8. **Please comment on the applicant's strengths or weaknesses and/or any other information that you may have to assist in this evaluation.**

_____

_____

9. **The above comments are based on the following:**

☐ Personal observation ☐ General impression ☐ A composite of evaluations by other physicians

☐ Other_____

10. **Recommendations:**

☐ Recommend for licensure in Massachusetts.

☐ Recommend for licensure in Massachusetts, with the following reservations:

_____

☐ Do not recommend for the following reason(s):

_____

Signature of Evaluator: _____ (*check one)* ☐ M.D. or ☐ D.O.

Name of Evaluator (Printed):_____ Date: _____/_____/_____

Title/Position: _____

E-mail address:_____Phone number:_____

PLEASE RETURN THE COMPLETED EVALUATION TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE AFFIXED ACROSS THE ENVELOPE SEAL.

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

POLICY ON SUPERVISOR EVALUATIONS

POLICY 2017- 03

Adopted September 28, 2017

The Board and its Licensing Committee (Board) undertakes a rigorous and comprehensive process when evaluating the professional qualifications of an Applicant for a limited or initial license in Massachusetts. The honest and impartial assessment of an Applicant by his or her Program Director or Residency Director is a crucial component in the Board's evaluative process.

All persons who submit Evaluations to the Board shall avoid any actual or perceived conflict of interest so as to ensure that the conflict does not affect patient safety, quality of care or the integrity of the services provided by the Board. A "conflict of interest" is a situation where financial, professional or personal interests (including the interests of immediate family members), may compromise one's professional judgment or official responsibilities. A conflict of interest exists when an Evaluator may gain financially or professionally from an Applicant's prospective employment.

All persons who submit an evaluation to the Board shall certify that they have knowledge of the Applicant's performance and have reviewed the Applicant's training record; that there is no evidence of any unprofessional behavior or any serious question of clinical competence; that the applicant has demonstrated competency to practice medicine without direct supervision; and that the Evaluator is the supervisor and has no conflict of interest, personally, professionally or financially, in recommending the Applicant for licensure.

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

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were ever licensed in the past. Contact the individual state board(s) for information on verification processing fees before you mail this form.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician:_____ Date:____/_____/_____

Print or type name:_____

License number:_____ Status of license: ☐ Active ☐ Inactive ☐Other_____

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation:_____
2. Date of graduation: ____/____/____ License number:_____ Date of issue: ____/____/_____
3. Basis for licensure:_____
   Name(s) of medical licensing examinations(s)
4. Expiration date of license: _____/_____/_____
5. Status of license (*check one*): ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain:_____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain:_____

Other derogatory information:_____

Remarks:_____

Signed:_____

BOARD SEAL

Print Name:_____

Title:_____

State Board:_____ Date: ____/____/____

PLEASE RETURN THE STATE LICENSE VERIFICATION TO THE APPLICANT IN A SEALED ENVELOPE WITH THE BOARD SEAL OR THE SIGNATURE OF THE PERSON COMPLETING THIS FORM ON THE BACK OF THE ENVELOPE.