Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required.

1. Current Status: Active Registration No.: 78814 Renewal Date: 03/19/2001

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

☒ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
INGRID A BALCOMB
131 OLD ROAD TO 9 ACRE
JOHN CUMING BLDG/STE 220
CONCORD, MA 01742-4162

B) Home Address:

Home Phone:

Business Phone: 978-371-1396

Please make corrections (type or print)

Other Name(s):

Mailing Address:
City/Town: State:
Zip: Country:

Business Address:
City/Town: State:
Zip: Country:
Business Telephone: (978) 371-1396

Home Address:
City/Town: State:
Zip: Country:
Home Telephone: (

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: b) Sex: F

c) SS#:

5. a) Name of Medical School:

Faculty of Medicine, University of Dalhousie

b) Year Graduated: 1976 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	0 40	Obstetrics and Gynecology
	0	

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

Fellow Royal College Surgeons of Canada - Board Certified in Ob/Gyne in Canada

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)

b) States where you were previously licensed (Abbr.)

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 18 / ✓ (AP) 100 % Facility Code: 168 / (AP) % Facility Code: 92 / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s):

PRINT YOUR LAST NAME: Balcomb LICENSE NUMBER: 78814

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Promutual Ins. Co. Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 10/15
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 50 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: H Balcomb Date: 2/20/01

YOU MUST SIGN AND INCLUDE PART B. WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope**

Registration No.: 78814 Renewal Date: 03/19/1999 1. Current Status: Active

3/18/99

If you want to change your current status, please indicate below: (Check one).

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see below *) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
INGRID A BALCOMB, M.D.
131 OLD ROAD TO 9 ACRE
JOHN CUMING BLDG/STE 220
CONCORD, MA 01742-4162

B) Home Address:

will change again after April 1

Home Phone:
Business Phone: (978)371-1396

4. A) Date of Birth: Sex: F
B) SS#:

5. A) Name of Medical School:
Faculty of Medicine, University of Dalhousie
B) Year Graduated: 1976 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	60	Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Other Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Home: ( ) _____
Business: ( ) _____

Date of Birth: (M/D/Y): ___/___/___ Sex: ☐ M ☐ F
SS#: ___-___-___

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___	___
___	___

If OS, Print Specialty: _____

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OBG – ~~Code~~ Canadian Board of Certification FRCSC.

Code: _____ Code: _____

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts:

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.**

♻

PRINT NAME AND NUMBER: Last Name: Balcomb Registration Number: 78811

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 18 / ✓ (AP) 100 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %

Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %

If 999, print name(s): ___

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: ~~Promutual~~ - Medical Professional Mutual Ins Co - Policy #- 1-19278 Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: ___

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☑ No

13. A. What is your principal work setting? (See Table 4) 10 / 15

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 49 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 50 % if ob considered primary care

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: Ingrid N Balcomb Date: 3 / 11 / 99

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

ELN 4/19

RECEIVED RECEIVED

BOARD OF REGISTRATION IN MEDICINE

Registration No.: 78814 Renewal Date: 03/19/97

1. Activity Status: (Check only one) ☒ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

3. A) Mailing/Business Address:
INGRID A BALCOMB, M.D.
JOHN CUMING BUILDING
EMERSON HOSP, SUITE 490
CONCORD, MA 01742

B) Home Address:

Home Phone:
Business Phone: (508)369-7627

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 12/29/93 D) SS#

5. A) Name of Medical School:
Faculty of Medicine, University of Dalhousie
B) Year Graduated: 76 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: Code: FRCS(C)

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts:

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Corrections (typed only):

Other Name(s):
Mailing Addr
City/Town: State:
Zip: Country:
Other Address:
City/Town: State:
Zip: Country:
Home: ( )
Business: ( )
Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:
Full Name of Medical School:
Year Graduated: Degree (MD/DO):
Code(s) Hours Per Week in Mass. 60+
If OS, Print Specialty:
Code: Code:
Federal (DEA):
Mass:
Abbr:
Abbr:

*If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts

11

PRINT NAME AND NUMBER: Last Name: Balcomb Registration Number: 78814

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).

Facility Code: 181 (AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)
Facility Code: 1681 (AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3) N/A

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ___ b) Letter of Credit
Name of Insurer: PROMUTUAL

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

I am (check one) a)_____ Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 10 20

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 45 hrs/wk b) inpatient care 8 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? _____%

Is obstetrics considered primary care? if no - 50% - if not <5%

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption		

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature Ingrid A Balcomb Date: 3/18/97.

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
78814	ACTIVE	$250.00	03/19/95	$25.00

Mailing Address:
INGRID A BALCOMB, M.D.
232 COLONIAL HEIGHTS
FREDERICTON
NEW BRUNSWICK, E3B-5M1
CANADA

Correction of Mailing Address

Address (Mailing):
City/Town:
State:
Country:

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- **Add late fee if necessary.**
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.

For Office Use Only
RECEIVED
BOARD OF REGISTRATION IN MEDICINE

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. Business Address:

3. Date of Birth: Sex: F
Lic. Issue Date: 12/29/93 SS#: - -

Home Phone Business Phone
( )# -

4. Name of Medical School:
Faculty of Medicine, University of Dalhousie
Year Graduated: 76 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr):
b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 1):

Code	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
Code: Code:

8. Drug license number(s), if any: a) Federal (DEA)
b) Massachusetts

Corrections of Pre-Printed Information

Name: DR. I. A. BALCOMB
Address: Suite 490 John Cuming Bldg
City/Town: Concord
State: MA Zip: 01742
Country:

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:

Home: Business: 508·369·7627

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code	Hours per Week in Mass.
O B G	50+

If OS, print specialty:

Code: Code:

Federal (DEA):
Mass:

9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Physician Last Name: Balcomb Registration Number: 78814

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 1 8 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 1 6 8 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

11. My medical malpractice insurance is covered by (a) Insurance Carrier ✓ (b) Letter of Credit ___ If applicable, check one by ✓

List Insurer: Mass. Medical Professional Insurance Assoc. (Protective by ✓ Wyman)

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___

State how otherwise exempt: ___

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No ___ (Check one)

13. a) What is your principal work setting? (See Table 4) 10 & 15

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 40-50 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 10+ hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) ___ %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ ___ No, waiver requested ___ No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: J Balcomb Date: 3/17/95

I. PHYSICIAN INFORMATION

INGRID	A	BALCOMB	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 78814
License Status Active

First Issue Date 12/29/93

Hospital Affiliation

John Cuming Building
Emerson Hosp,Suite 490
Concord, MA 01742
U.S.A.
(508) 369-7627

Make address corrections here:

Make any corrections to above here.
in addition:
Mass. General Hospital - teaching - Attending at Gyne clinic

Insurance Plan Affiliation:
PROMUTUAL

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No
Accept Medicaid? ☑ Yes ☐ No

II. EDUCATION & TRAINING

Faculty of Medicine, University of Dalhousie	MD	76
Medical School	*Degree*	*Date*

Make corrections here

Obs-Gynecology Dalhousie University	July '81	June '85
Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Royal College of Physicians & Surgeons of Canada

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action
N/A.		

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action
N/A.		

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint

nil

VII. MALPRACTICE

No. of Years in Practice: # 10

Details of claims paid for Dr. BALCOMB

Date	Amount Paid	Basis for Complaint
	0.0000	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
nil.	

Note: Please return the survey in the enclosed envelope to:

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: $350.00 TO BE SUBMITTED

Filed: 10/26/93 For Office Use Application #
By: OAT
Form of Fee: $350 Certificate # 78814 Date of Issue 12/29/93

Please Print SWORN STATEMENT Date: Sept. 22, 1993

Name INGRID ANITA BALCOMB Address
First Middle Last

Date of Birth

Place of Birth Annapolis Royal Nova Scotia

Name on Birth Certificate as above Canada Phone #

Pre-Medical Education	Medical Education
School Mount Allison University	School Dalhousie University
Years Attended 1968-1971	Years Attended 1971-1976

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Bridgewater, Nova Scotia	general practitioner	1977-1981
Residency Program	Obs/Gyne - Dalhousie University	1981-198
Fredericton, New Brunswick	Obs/Gyne - Active Staff - Doctor Everett Chalmers Hospital	1986-present
Bathurst New Brunswick Chaleur Regional Hospital	Obs/Gyne - ~~hospital~~ Tenure	1989-present

Is this your first full license? No If applicable, please list all other states where you are or have been licensed:
NOVA SCOTIA NEW BRUNSWICK

Other names under which you have been licensed:
INGRID A. ROMNEY

List Specialty Boards by which you are certified:
FRCS(C) - Obs/Gyne

REASON APPLYING FOR A MA LICENSE Position procured - Concord, Mass.
Anticipated starting date if you have position pending in Massachusetts: 01/30/94

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

AFFIDAVIT OF APPLICANT:
I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

Ingrid A Balcomb Date: 22/09/93
SIGNATURE OF APPLICANT

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: _____ Day time phone #: _____

MAILING ADDRESS: _____ Business Address:

_____

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
12. Have you ever, for any reason, lost American Specialty Board Certification?		
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.
I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: _____ DATE: Oct 2/93.

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

FORM E

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it DIRECTLY TO THE ADDRESS ABOVE. This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT INGRID A. ROMNEY CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

MOUNT ALLISON SACKVILLE NB
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

DALHOUSIE HALIFAX NS
NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: DALHOUSIE UNIVERSITY
NAME OF MEDICAL SCHOOL

HALIFAX NS CANADA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT INGRID A. ROMNEY
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: DALHOUSIE UNIVERSITY
NAME OF MEDICAL SCHOOL

CONTINUED ON BACK OF THIS PAGE

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

FORM E CONTINUED

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

NAME OF APPLICANT INGRID A. ROMNEY.

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

	MONTH	DAY	YEAR	TO:	MONTH	DAY	YEAR
FROM:	Sept	9	1972	TO:	May	19	1973
FROM:	Sept	7	1973	TO:	May	18	1974
FROM:	Sept	6	1974	TO:	Mar	16	1975
FROM:	May	7	1975	TO:	May	2	1976
FROM:				TO:			
FROM:				TO:			
FROM:				TO:			

AND HAS RECEIVED/~~WILL RECEIVE~~ A DEGREE OF MD

ON 18 May 19 76.

Jean Gray
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

JEAN D. GRAY, M. D., FRCPC
Associate Dean
Postgraduate Medical Education
NAME AND TITLE (PLEASE TYPE OR PRINT)

Clinical Research Centre
Lower Level, Room c-18
5849 University Avenue
Halifax, Nova Scotia
Canada B3H 4H7

SCHOOL SEAL

DATE: 21 Oct 93

RETURN TO: BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please send this form directly to the Board at the above address. Your early response is greatly appreciated.

SIGNATURE OF PHYSICIAN*: Ingrid A Balcomb

NAME OF PHYSICIAN: INGRID ANITA BALCOLM LICENSE NUMBER: 4662

The State Board fills out the following information:

State of: NOVA SCOTIA Full Name of Licensee: INGRID ANITA BALCOMB

Graduate of: DALHOUSIE UNIVERSITY - 1976

License Number: 4662 Issue Date: JUNE 14th, 1977

By Endorsement/Reciprocity with: N/A By Your State Board's Written Examination? ___ Yes X No (on Credentials)

Is License current? ___ Yes N No

If No, why not? Allowed license to lapse end of 1985

Has this License been suspended or revoked? ___ Yes X No

If yes, why? N/A

Has licensee ever been on probation? ___ Yes X No

If yes, why? N/A

Has licensee ever been requested to appear before your Board? ___ Yes X No

If yes, why? N/A

Derogatory information, if any? None

Comments, if any? Was considered to be in good standing while holding licensure in Nova Scotia.

Signed: Bernard J Steele

Title: Dr. Bernard J. Steele, Registrar/Secretary

BOARD SEAL

State Board: Nova Scotia Date: November 26th, 1993

*NOTE TO APPLICANT: Most states charge a fee for this service. We suggest that you call the different states in which you are licensed before you mail this form.

/sw

RETURN TO: BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR, BOSTON, MA 02111

RECEIVED
OCT 18 1993
BOARD OF REGISTRATION IN MEDICINE

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please send this form directly to the Board at the above address. Your early response is greatly appreciated.

SIGNATURE OF PHYSICIAN: Ingrid A Balcomb

NAME OF PHYSICIAN: INGRID A. BALCOMB LICENSE NUMBER: 0709

THE STATE BOARD FILLS OUT THE FOLLOWING INFORMATION

State of: Province New Brunswick Full Name of Licensee: Dr. Ingrid Anita BALCOMB

Graduate of: Dalhousie University 1976

License Number: 0709 Issue Date: Jan. 1, 1986

Endorsement/Reciprocity with: _____

By Your State Board's Written Examination? _____ Yes _____ No LMCC, FRCSC

Is License Current: X Yes _____ No
If no, why not? _____

Has this License been suspended or revoked? _____ YES X NO
If yes, why? _____

Has Licensee ever been on probation? _____ YES X NO
If yes, why? _____

Has Licensee ever been requested to appear before your Board? ___ YES X NO
If yes, why _____

DEROGATORY INFORMATION, IF ANY? _____

Comments: _____

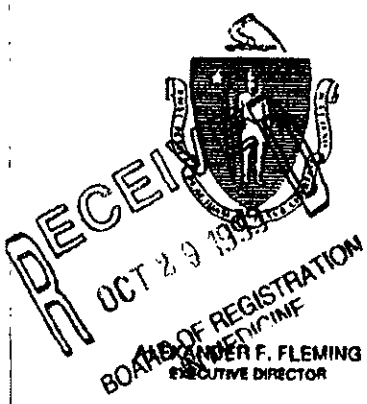
Signed: _____ Date: Oct. 12, 1993

Title: Registrar

STATE BOARD College of Physicians and Surgeons of New Brunswick CANADA

Most states charge a fee for this service. We suggest you call the different states in which you are licensed

Form H



Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

An Agency within the Executive Office of Consumer Affairs and Business Regulation

CERTIFICATION OF POST-GRADUATE MEDICAL TRAINING IN CANADA

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had post-graduate medical training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, Jean Gray (Name), Associate Dean (Title)

hereby certify that INGRID A. BALCOM (Name of applicant) has served 5 year(s) of post-graduate medical training as a rotating intern / internship / resident 1-4 (Position) in Obstetrics & Gyn (Specialty) at Dalhousie Univ. (Hospital), Halifax (City), NS (Province). This program is ✓ is not ___ accredited by the Royal College of Physicians and Surgeons in Canada. Dr. Balcom participated in this program from June 1976 (Month, Year) to June 1977 (Month, Year) and was issued ✓ was not issued ___ a July 1981 (Month, Year) certificate as proof of completion of said training. (If not issued a certificate, please explain)

CONTINUED ON BACK OF THIS PAGE

Form H
Page 2

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

Jean Gray
Signature of Director

JEAN D. GRAY, M. D., FRCPC
Associate Dean
Postgraduate Medical Education
Clinical Research Centre
Lower Level, Room c-18
5849 University Avenue
Halifax, Nova Scotia
Canada B3H 4H7

Name and title (please type or print)

Hospital Seal

Date 21 Oct 1993

RETURN THIS FORM DIRECTLY TO: Commonwealth of Massachusetts
Board of Regration in Medicine
10 West Streeet - Third Floor
Boston, Massachusetts 02111

Certification of Post-Graduate Training

FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, Glenn H. Gill, MD, FRCS(C) (Name), Director, Postgraduate Education, Dept.Obs, (Title) Dalhousie University, Halifax, Nova Scotia,

hereby certify that Dr. Ingrid Anita Balcomb has served 4 year(s)

of post-graduate training as a Resident (Position) in Obstetrics/Gynecology (Specialty)

at Dalhousie University (Hospital), Halifax (City), Nova Scotia, (State) Canada

This program is _____ is not X approved by the ACGME or the RRC.

Dr. Balcomb participated in this program from

July (Month), 1981 (Year) to June (Month), 1985 (Year) and was issued X was not

issued _____ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

_____

_____

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

G. Gill

Signature of Director

August 19, 1993

Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

Physician Registration Renewal Application

RECEIVED
JAN 17 2003
Board of Registration in Medicine

Before proceeding, *please read the instruction booklet*. Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. This completed renewal form with attachments must be returned in the *green* envelope *at least 4 weeks* before your renewal date.

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 78814 Renewal Date: 03/19/2003

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see instructions) ☐ Do not wish to renew

2. Other Name(s), if any, under which you were licensed:

A) Mailing/Business Address:
3. Ingrid A Balcomb
131 Old Road To 9 Acre Corner
John Cuming Building, Suite #2
Concord, MA 01742-4162

B) Home Address:

Home Phone:

Business Phone: (978)371-1396

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

Mailing Address: 131 ORNAC, Suite 220
City/Town: Concord State: MA
Zip: 01742 Country: USA

Business Address: Same as above
City/Town: State:
Zip: Country:
Business Telephone: (978) 371-1396

Home Address:
City/Town: State:
Zip: Country:
Home Telephone: ( )

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

4. a) Date of Birth: b) Sex: F
c) SS#:

5. a) Name of Medical School:
Faculty of Medicine, University of Dalhousie
b) Year Graduated: M.D. c) Degree: 1976

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: OG Code:

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)
b) States where you were previously licensed (Abbr.)

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

Facility Code: 921 / ✓ (AP) Ø % Facility Code: 18 / ✓ (AP) 100 % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 168 / ✓ (AP) Ø % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s):

PRINT YOUR LAST NAME: Balcomb LICENSE NUMBER: 78814

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): Promutual Policy dates: From: 5/01/02 To: 5/01/03

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 80 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. **CLAIMS MADE (New or Pending):** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS (Resolved):** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: [signature] Date: 01/14/03

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb **License No.:** 78814

PART A

1) Current Status: Active **Renewal Due Date:** 02/19/2005 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one). (*See Renewal Instructions, page 3.*)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

Please make corrections (print)

2a) MAILING ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

☐ *Check here to change this address*

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (____) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

Phone: (978)371-1396

☐ *Check here to change this address*

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (____) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 978 371-8277

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. *(See enclosed instructions and Renewal Instructions, page 4.)*

List Certifying Board(s) below:

Board Name	**ABMS**	**AOA**
Obstetrics + Gynecology	☐	☐
(Royal College of Surgeons	☐	☐
of Canada)	☐	☐
Ob/Gyne Speciality.	☐	☐

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Certificate/Subspecialty	**Correct?**	**Delete?**
Obstetrics & Gynecology	☒	☐
	☐	☐
	☐	☐
	☐	☐

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb **License No.: 78814**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	___ ___ ___ ___ ___ ___ ___ ___
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	___ ___ ___ ___ ___ ___ ___ ___

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*

Principal Work Setting: Private Office

Change to: _____ Hours per Week: _____

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	# Hours per Week
Brigham & Women's Hospital	☑			
Emerson Hospital	☐	Admitting		80
Massachusetts General Hospital	☑			
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: 30 hrs/wk

b) outpatient care 80 hrs/wk Change to: 50 hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

My medical liability insurance is provided through: (check one)

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 5/1/04 To 5/1/05
(required)

☐ **Letter of Credit subject to Board approval** ***(attach a copy)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb **License No.: 78814**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* If Yes, please complete Form PCA-O "Office Based Surgery"	**Yes** **No**

In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved; Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb **License No.: 78814**

PHYSICIAN PROFILE

☐ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☒ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

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 penalties of perjury, I declare that I have examined this renewal 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. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: IABalcomb Date: 12/28/04

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

Current Status: Active **License Expiration Date:** 3/19/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America

Home Address:

Business Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America
(978) 371-1396

3) **Email Address:**

4) **Fax Number:** (978) 371-8277

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Emerson Hospital	Concord
Emerson Hospital	Westford

Primary Office
Private Office Concord

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 30 hrs/wk
b) outpatient care 50 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Medical Professional Mutual Ins Co	05/01/2010	05/01/2011	Occurrence Policy

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 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.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

PART A

1) Current Status: Active **Renewal Due Date:** 02/19/2007 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page* 3.)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

Please make corrections (print)

2a) MAILING ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

☑ *Check here to change this address*

Mailing Address: 131 ORNAC Suite 830
City/Town: CONCORD State: MA
Zip: 01742 Country: USA

RECEIVED
FEB 7 2007
Board of Registration in Medicine

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address:
City/Town: State:
Zip: Country:
Home Telephone: ( )

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

Phone: (978)371-1396

☑ *Check here to change this address*

Business Address: 131 ORNAC Suite 830
City/Town: CONCORD State: MA
Zip: 01742 Country: USA
Business Telephone: (978) 371-1396

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 978-371-8277

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. *(See enclosed instructions and Renewal Instructions, page 4.)*

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
(Royal College of Surgeons of CANADA)			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Bakomb, M.D. **License No.: 78814**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	**Location (City or Town)**	**State**	**Delete?**
Emerson Hospital	Concord	MA	☐
AFA OB/gyn, PC	Concord	MA	☐
Kropia/Dr First	internet	—	☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ____ hrs/wk

b) outpatient care 50 hrs/wk Change to: ____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: ____

Policy dates: From 5/1/06 To 5/1/07

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one: ☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: ____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. *(See Renewal Instructions, page 8)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW:** Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

PART C

Check One: **PHYSICIAN PROFILE**

☐ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☑ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

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 with 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. 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 the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq*. I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal 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 renewal of a 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: IBalcomb Date: 2/7/07

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

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

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 **will be required to obtain an NPI by May 23, 2007.**

In order for your license to be renewed you 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 by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- [x] My current NPI is: 1 2 7 5 5 1 9 3 4 0
- [ ] I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- [ ] 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.
- [ ] As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). 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.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	Obstetrics + Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

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): CANADA

Gender: [ ] Male [x] 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

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: IABalcomb Date: 2/7/07

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

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

PART A

1) Current Status: Active **Renewal Due Date:** 02/19/2007 **Birth Date**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page* 3.)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

Please make corrections (print)

2a) MAILING ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

☑ *Check here to change this address*

RECEIVED
FEB 7 2007
Board of Registration in Medicine

Mailing Address: 131 ORNAC Suite 830
City/Town: CONCORD State: MA
Zip: 01742 Country: USA

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address:
City/Town: State:
Zip: Country:
Home Telephone: ( )

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
131 Ornac
Suite 220
Concord, MA 01742

Phone: (978)371-1396

☑ *Check here to change this address*

Business Address: 131 ORNAC Suite 830
City/Town: CONCORD State: MA
Zip: 01742 Country: USA
Business Telephone: (978) 371-1396

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 978-371-8277

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information.
(See enclosed instructions and Renewal Instructions, page 4.)

List Certifying Board(s) below: / **Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**

Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
(Royal College of Surgeons of CANADA)			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:	_____	___ ___ ___ ___ ___ ___ ___
b) Federal (DEA):	_____	**9) States where you were previously licensed**
c) Federal (DEA) XS:	_____	___ ___ ___ ___ ___ ___ ___

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	**Location (City or Town)**	**State**	**Delete?**
Emerson Hospital	Concord	MA	☐
AFA OB/gyn PC	Concord	MA	☐
Procopia / Dr First	internet	—	☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: _____ hrs/wk

b) outpatient care 50 hrs/wk Change to: _____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 5/1/06 To 5/1/07

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one: ☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. *(See Renewal Instructions, page 8.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

b) If no, are you requesting a CME waiver? ☐ Yes ☐ No

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

PART C

Check One: **PHYSICIAN PROFILE**

☐ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☑ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

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 with 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. 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 the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq*. I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal 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 renewal of a 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: IBalcomb Date: 2/7/07

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

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

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 **will be required to obtain an NPI by May 23, 2007.**

In order for your license to be renewed you 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 by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- ☑ My current NPI is: 1 2 7 5 5 1 9 3 4 0
- ☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- ☐ 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.
- ☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). 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.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	Obstetrics + Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

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): CANADA

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

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: IABalcomb Date: 2/7/07

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

Massachusetts Board of Registration in Medicine Physician Profile

Ingrid A. Balcomb, M.D.

I. **Physician Information**

(The information in sections I - VI has been provided by the physician.)

License Status:	**Active**
License Issue Date:	12/29/1993
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Private Office
Business Address:	131 Ornac Suite ~~220~~ 830 Concord, MA 01742
Phone:	(978) 371-1396
Translation Services Available:	None Reported
Insurance Plans Accepted:	Aetna Blue Cross Blue Shield Cigna Costcare Harvard Pilgrim Health Care Medicaid Medicare Prudential Insurance Company of America Tufts
Hospital Affiliations:	Emerson Hospital (Admitting)

United Healthcare
PHCS
Beech Street

II. Education & Training

Medical School: Faculty of Medicine, University of Dalhousie

Graduation Date: 1976

Post Graduate Training: Dalhousie University (7/1/1981-6/1/1985)

III. Specialty

Area of Specialty: Obstetrics and Gynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Obstetrics & Gynecology	Obstetrics and Gynecology	

V. Honors and Awards

Board Certified in Canada by the Royal College of Surgeons of Canada
Fellow, American College of OB/GYN

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.
When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Balcomb has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Balcomb has had no criminal convictions in the past ten years.

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Balcomb has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Balcomb has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 617-654-9830
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search

Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

privacy policy site map

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

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PART A

1) **Current Status:** Active **Renewal Due Date:** 02/19/2009 **Birth Date:**

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:
Check only one: (*See Renewal Instructions, page* 3.)

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.

Please make corrections (print)

2a) MAILING ADDRESS
131 Ornac
Suite 830
Concord, MA 01742

☐ *Check here to change this address*

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

2b) HOME ADDRESS

RECEIVED
FEB 17 2009
Board of Registration in Medicine

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (____) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
131 Ornac
Suite 830
Concord, MA 01742

Phone: (978)371-1396

☐ *Check here to change this address*

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (____) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 978-371-8277

Correct your E-mail and Fax Number below:
_____
_____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information.
(See enclosed instructions and Renewal Instructions, page 4.)

List Certifying Board(s) below:

Board Name	**ABMS or AOA**
Obstetrics & Gynecology	ABMS

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Certificate/Subspecialty	**Delete?**
Obstetrics and Gynecology	☐
	☐
	☐
	☐

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

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(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:	_____	___ ___ ___ ___ ___ ___ ___
b) Federal (DEA):	_____	**9) States where you were previously licensed**
c) Federal (DEA) XS:	_____	___ ___ ___ ___ ___ ___ ___

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	**Location (City or Town)**	**State**	**Delete?**
Emerson Hospital	Concord	MA	☐
131 ORNAC, suite 830	Concord	MA	☐
490 Boston Post Rd, suite 1001	Sudbury	MA	☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ____ hrs/wk

b) outpatient care 50 hrs/wk Change to: ____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 5/01/08 To 5/01/09

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***

☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**

Check one: ☐ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

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In questions 14-21, the phrase "time period" refers to the following -- all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application. *(See Renewal Instructions, page 5.)*

You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

b) If no, are you requesting a CME waiver? ☐ Yes ☐ No

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.: 78814**

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PART C

Check One: **PHYSICIAN PROFILE**

☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

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 with 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. 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 the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq*. I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal 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 renewal of a 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: Ingrid A Balcomb Date: 2/3/'09

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

Current Status: Active **License Expiration Date:** 3/19/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America

Home Address:

Business Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America
(978) 371-1396

3) **Email Address:**

4) **Fax Number:** (978) 371-8277

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Emerson Hospital	Sudbury
Emerson Hospital	Leominster

Emerson Hospital	Concord
Emerson Hospital	Westford
Primary Office	Concord
Private Office	Concord

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) Inpatient care** 30 hrs/wk
b) outpatient care 50 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	05/01/2014	05/01/2015	Occurrence Policy

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes. Yes

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 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.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ingrid A Balcomb, M.D. **License No.:** 78814

Current Status: Active **License Expiration Date:** 3/19/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America

Home Address:

Business Address:
131 Ornac
Suite 830
Concord
Massachusetts - 01742
United States of America
(978) 371-1396

3) **Email Address:**

4) **Fax Number:** (978) 371-8277

5) **Specialties**
Obstetrics and Gynecology

6) **Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information**

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

10) **Work Sites**
List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Emerson Hospital	Concord
Emerson Hospital	Westford

Primary Office
Private Office Concord

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 30 hrs/wk
b) outpatient care 50 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	05/01/2012	05/01/2013	Occurrence Policy

13) Do you perform any surgery in your Massachusetts office?

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?

24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

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10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9368

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

REDACTED COPY

December 26, 2006

Ingrid A. Balcomb, M.D.
C/o Pamala S. Gilman, Esquire
Taylor, Duane, Barton & Gilman
160 Federal Street
Boston, MA 02110

Re:
Docket Number: 06-468

Dear Dr. Balcomb:

The Complaint Committee of the Board of Registration in Medicine met on December 20, 2006, and carefully considered the information both you and the complainant furnished in the above-referenced matter. They determined that no further action is warranted and the matter has been closed. Despite the decision to close the above complaint, the Board reserves the right to reopen the complaint should you commit any violations of Board statutes or regulations in the future.

If you have any questions regarding this matter, I can be reached at the number or address listed above.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/jls

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

December 26, 2006

Re: Ingrid A. Balcomb, M.D.
Docket Number: 06-468

Dear

The Complaint Committee of the Board carefully considered the information you furnished it regarding your complaint against the physician referenced above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues that were raised.

After a thorough review of this evidence, the Committee determined that the complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions regarding this matter, I can be reached at the address or number listed above.

Thank you again for your concern.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/jls

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
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KERRY HEALEY
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Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
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MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

September 26, 2006

Ingrid A. Balcomb, M.D.
131 Ornac
Suite 220
Concord, Massachusetts 01742

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

7005 1820 0005 8269 7855

Re:
Docket Number: 06-468

Dear Dr. Balcomb:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed.

Please provide a written response, signed by you, to the issues raised in the enclosed material. As part of your response, you may include any materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee.

Your response must be sent to me, at the address above, within thirty days of your receipt of this letter. After your response is received, the case will be reviewed and a determination will be made about how to proceed. You will be notified of this decision.

Thank you for your attention to this request.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/jls
Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

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MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

September 26, 2006

Re: Ingrid A. Balcomb, M.D.
Docket Number: 06-468

Dear

Your complaint regarding the physician named above has been received. The physician involved has been asked to respond in writing to your complaint. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to me at the address above.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/jls

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

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KERRY HEALEY
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MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

December 14, 2006

Re: Ingrid A. Balcomb, M.D.
Docket Number: 06-468

Dear :

Enclosed please find a copy of Dr. Balcomb's response. You will be notified when there is a disposition in this matter.

In the meantime if you have any questions, I can be reached at (617) 654-9800 ext. 4033.

Very truly yours,

Jennifer A. Brown

Jennifer A. Brown
Consumer Protection Manager

JAB/jls
Enclosure

A.F.A. Obstetrics and Gynecology, P.C.

Ingrid A. Balcomb, M.D., FRCS(C), FACOG
Kitsa C. Kondylis, M.D., FACOG
Lesley L. Kenney, RNC, MS

November 27, 2006

BY CERTIFIED MAIL

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
Attn.: Jennifer Brown
Consumer Protection Manager

Re:
Docket Number: 06-468

Dear Ms. Brown:

I am writing in response to your letters dated September 26, 2006 and October 4, 2006 and appreciate you allowing me more time to respond. Your letter indicates that you are investigating a complaint concerning my care of during her pregnancy that resulted in a miscarriage in May, 2006. I understand that I am authorized to discuss the care that I provided to ; and that disclosure of such information does not breach my obligations to maintain patient confidentiality.

As an initial matter, I am a graduate of Dalhousie University Medical School, which is in Nova Scotia, Canada and completed my internship and residency as an obstetrician/gynecologist, also in Canada. I came to the United States in 1994 and have been practicing as an ob/gyn in Concord, MA in a group practice affiliated with Emerson Hospital. In addition to my clinical responsibilities, I was Chief of the Department of Ob/Gyn at Emerson Hospital until July,2006, and have also been a clinical instructor at Massachusetts General Hospital for several years.

Unfortunately, miscarried at 16 weeks from presumed chorioamnionitis. Chorioamnionitis is an inflammation of the chorion and the amnion, which are the membranes that surround the fetus. Chorioamnionitis may be due to bacteria ascending from the mother's genital tract into the uterus, infecting the membranes and amniotic fluid. It is extremely dangerous to the mother and to the child and greatly increases the risk of preterm labor and, if the child survives, cerebral palsy. Chorioamnionitis is usually diagnosed clinically by symptoms, including fever, an increased heart rate of the mother or

131 ORNAC, Suite 830, Concord, MA 01742
Telephone: (978) 371-1396 Fax:(978) 371-8277

the child, a tender or painful uterus and foul odor of the amniotic fluid. The treatment for chorioamnionitis is delivery if the child is viable and antibiotics to the mother and child. If the child is not viable, miscarriage results.

did not exhibit any signs of chorioamnionitis during her prenatal visits to my office. Since I do not have her Hospital records, I do not recall whether she exhibited any such signs during her admission for unrelated reasons on May 1, 2006. In case, it is presumed that she had chorioamnionitis because the baby did not have any genetic abnormalities to account for the miscarriage. What is not known, however, is what caused chorioamnionitis.

After the miscarriage, I spent several hours with and her husband to provide emotional support and to explain what had occurred. I advised them that although it is likely that she had chorioamnionitis, it is possible that the chorioamnionitis was caused by a very common viral infection called cytomegalovirus or CMV. By age 30, approximately half of all adults in the United States have been infected with CMV but the virus is typically dormant for life. Since tested positive for IGG, which is one of the antibodies that form when you have had a CMV infection, I explained that either was recently exposed or had been exposed in the past. Regardless as to what caused chorioamnionitis, the baby could not have survived.

Despite my efforts to explain and comfort and her husband, they did not appear to appreciate the gravity of the diagnosis of chorioamnionitis and the uncertainty of its cause. I, therefore, wrote the medical terms for them on a piece of paper, which is enclosed, and also provided them with a complete copy of their medical records. Based on the statements made by in her complaint, however, it appears that she continues to believe that her diagnosis was either delayed or incorrect, neither of which is true.

By way of background, first contacted our office on February 15, 2006 complaining of pink spotting. Since she was not an established patient, she was advised to come to the office. The usual practice would have been for her to be seen by the provider who was best able to accommodate an unscheduled visit. Accordingly, she was seen the following day by , who is a nurse practitioner with approximately 13 years of ob/gyn experience. obtained a history from , scheduled her for an ultrasound to evaluate the viability of the pregnancy and also scheduled for an initial obstetrical visit on February 28, 2006, which is an extended visit with a nurse practitioner to discuss general obstetrical issues.

Consistent with our office practice to see obstetrical patients approximately every 4 weeks during the first and second trimesters and to rotate visits among the 2 nurse practitioners and myself, was then seen by , who is also a nurse

practitioner with approximately 22 years of ob/gyn experience, for a further routine obstetrical visit on March 28, 2006 and was scheduled to be seen by me on May 2, 2006. The May 2, 2006 visit did not take place, however, because was admitted to the Hospital on May 1, 2006 and miscarried that night.

In addition to her regularly scheduled obstetrical visits, ; was seen at my office for 6 additional extra or problem visits during the period February through May 1, 2006 and spoke to a nurse or nurse practitioner at my office by telephone on approximately 10 occasions during the same time frame. Many of these unscheduled appointments were the result of her presenting herself to the office without prior contact. Although I do not recall whether I personally examined belly, both and discussed her care with me on a regular basis. In addition, I specifically recall that consulted me during March 13, 2006 visit and that, in response, I entered the examination room, evaluated condition and co-signed note with my signature "B", that appears in the bottom right corner of the page. also consulted me during March 17, 2006 visit regarding impaction. I recall that I spoke with about her condition and advised her to take her medications regularly to avoid any similar problems in the future. I also reviewed chart at some point in April, 2006 and noted that she had been admitted to the hospital twice during her first trimester. I also attended her during the hospitalizations when I did hospital rounds.

During the course of her pregnancy, complained of three ongoing problems which we appropriately addressed. First, she experienced vomiting, which is not uncommon. She was given IV hydration when needed and medications as tolerated. also experienced spotting throughout. She was routinely examined to determine if she had a local lesion and also had two ultrasounds to determine if she had a hematoma or, after 12 weeks gestation, a placental abnormality. No cause was identified although vomiting alone can break the blood vessels in the cervix and cause spotting. Finally, although complained of an intermittent fever, she did not have an underlying disease process by history and her temperature never approached 101.5, which might then have required treatment. In fact, although called on March 21, 2006 and stated that she had a fever of 105 on a Chinese thermometer, she called back shortly thereafter to confirm that her temperature was 100.5. She also stated on May 1, 2006 that she had been having a low grade fever of 100 but her temperature when seen in the office that day was 98.4.

In response to specific criticisms, I offer the following: (1) was not a high risk patient when she was seen at my office. As a result of her chorioamnionitis and second trimester loss, she is a high risk patient for any future pregnancy. The care provided to her throughout her pregnancy was entirely appropriate, all necessary tests were obtained and consultations were sought with me when needed. Had she

continued to receive care by my office, she would have been seen by me on her third regularly scheduled visit. Indeed, in reviewing our computerized appointment schedule, which is also attached, was actually scheduled to be seen by me on her second visit on March 30, 2006 but her appointment was cancelled and rescheduled with two days earlier; (2) was treated for a presumptive urinary tract infection. Since the lab results are typically not available for 48 hours, it is customary to prescribe an antibiotic pending receipt of the lab results. Our office changed from the Emerson Hospital lab to Quest Diagnostic lab in late April, 2006. Regrettably, on April 28, 2006, urine specimen was sent to new lab but with an old requisition. According, the lab was unable to process the test. As it turned out, however, was admitted to the hospital on May 1, 2006 because of low sodium and low calcium and was found to have no evidence of a urinary tract infection; (3) All treatment decisions are based on medical need and not monetary reimbursement. condition did not warrant IV therapy. Whether or not required IV therapy, I would not have received payment because the services would not have been provided by me; and (4) I advised that CMV was a possible cause of her chorioamnionitis. No definitive cause can be determined.

In addition to the handwritten note that I provided to and her husband and my office's computerized appointment schedule, I am enclosing complete medical chart. Please do not hesitate to contact me if you have any additional questions.

Thank you for your consideration.

Very truly yours,

Ingrid Balcomb, M.D.

IAB/
Encs.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite G-4
Boston, MA 02118

RECEIVED
AUG 29 2006
Board of Registration in Medicine

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☒ Mrs. ☐ Ms. ☐ Mr. Your First Name _____ Your Last Name _____ Patient Name (if different) _____

Street Address _____ Mailing Address (if different) _____

City _____ State _____ Zip Code _____

Business/Daytime Phone _____ Home Phone _____

Complaint against M.D. X, D.O. _____, Acupuncturist _____.

(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)

This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.

Ingrid A BALCOMB

Address 131 Ornac Suite 220

City Concord State MA Zip Code 01742

Business Phone 978-371-1396

Name and Location of Health Care Facility (if known)

AFA OB&GYN 131 Ornac Suite 220 Concord MA 01742

Nature of Complaint

- ☒ Substandard Medical Care
- ☒ Professional Misconduct
- ☐ Sexual Misconduct
- ☐ Rude or Discourteous Behavior
- ☐ Impaired by Alcohol or Drugs
- ☐ Impaired by Mental or Emotional Illness
- ☐ Failure to Provide Medical Records
- ☐ Overcharge for Medical Records
- ☐ Drug Dealing
- ☐ Criminal Conviction
- ☒ Patient Neglect/Abandonment
- ☐ Unlawful Discrimination
- ☐ Billing for Services Not Rendered
- ☒ Failure to Supervise Staff
- ☐ False Advertising
- ☐ Fraud
- ☐ OTHER _____

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: 8/25/2006
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

Signature of Patient: _____ Date: _____
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

_____

_____

_____

_____

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☐ Yes, ☒ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☒ No

How long have you (or patient) been under this physician's care?
☐ 1 to 30 days, ☒ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☒ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other_____

Are you (or patient) expected to pay a portion of this bill out of pocket?
☐ Yes, ☒ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☒ No

Is the fee or copayment in dispute?
☐ Yes, ☒ No

Has the physician been contacted about this complaint?
☒ Yes, ☐ No

Dates of Treatment: Mainly April 28 - May 1st, 2006, All periods From Feb - May, 2006

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

We will attach the whole procedure in detail in seperated paper. Here we only list the points of complaint.

1. I am a high-risk patient. From Feb to May 1st, 2006, I have visited Dr. Balcomb's clinic about 10 times. I had never seen Dr. Balcomb in the examination room. all checkings were made by her nurses. She had never talked with me in her clinic except "Hi!" in lobby;

2. Insisting wrong diagnosis without necessary checking (lab test) I had a low fever and bleeding. Dr. Balcomb insisted I had Urine Infection without checking Blood and Urine which should only take 2 hours. This didn't follow the basic logic to exclude Uterine infection.

3. After I vomitted oral antibiotic medicine, Dr. Balcomb didn't take other treatments, such as I.V. She insisted that I only had low fever, if she gave me I.V., she probably could not get paid. She didn't think about patient's health but money.

4. After Miscarriage happeded, Dr. Balcomb gave us the apparent wrong explaination. She said I had CMV infection that caused the infection. But another doctor said it can be any other infection but CMV certainly.

Attach copies of related documents to this form.

The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: _____ Date: 8/27/2006

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston MA 02118

vs Dr Balcomb

1. Background

has kept vomiting for 8 weeks from about 5th week and stayed in bed for 5 weeks. After 10 days bleeding and 5 days' low fever, she lost her baby on the exact 16th week.

2. Events in Time Order
   - In the afternoon on April 27th, 2006, felt fever and weak. Then came back to home from work and had a rest, and began to take Tylenol.
   - She had abnormal uterine bleeding (from several days ago) and the body temperature ranged "99-100" after taking Tylenol;
   - In the morning on April 28th, 2006, called the Dr Balcomb's office and got one appointment at the early time in the afternoon.
     She had abnormal uterine bleeding and the body temperature ranged "99-100" after taking Tylenol;
   - Before the checking, gave the routine Urine sample for culture.
   - When saw the Dr Balcomb's nurse, the nurse diagnosed as: Abnormal Uterine Bleeding and Urine system infection without any lab test/result.
   - The nurse insisted that the fever had nothing to do with pregnancy based on their experience but not based on lab result.

Question: Why did the Dr Balcomb office exclude uterine system infection without doing any lab work that could take less than 2 hours?
Insisted wrong diagnosis without any basic logic. Even from the general patient knowledge, it couldn't exclude Uterine System.

- Also, the nurse gave . the prescription antibiotic medicine "Amoxicillin". And the nurse let keep taking Tylenol for fever.
- At 3PM of same day, April 28th, 2006, took "Amoxicillin" and began to keep vomiting. She called Dr Balcomb's office. Dr Balcomb told to stop using "Amoxicillin" and keeps using Tylenol only.

She had abnormal uterine bleeding and the body temperature ranged "99-100" after taking Tylenol;

Question: If the oral antibiotic medicine couldn't be used, why did they change to other forms with the same medicine?

- In the evening of April 29th, 2006, felt the fever was very uncomfortable and called Dr Balcomb's office. The doctor herself called back and told "keep taking Tylenol if the fever can be kept below 100.5 degree. And call her office in the early time of Next Monday."