90-Day Form

Dear Doctor,

Renewal of your medical license will occur on your first birthday after your license is issued, unless your birthday falls within ninety (90) days of your license issue date. If your first birthday is within the 90-day time period that your license is issued, you will not be required to renew your license until your following birthday. Example: If your birthday falls on September 1, 2014, and your license is issued on July 1, 2014, your renewal date will be September 1, 2015. However, if your birthday falls on September 1, 2014, and your full license is issued on January 1, 2014, you will be required to renew your full license by your birthday on September 1, 2014. Renewals thereafter will be on a two-year birthday cycle. Please select one of the choices below and return this form with your Full License application.

Thank you.

Please select one of the boxes below:

☑ Do not hold my Full License Application; send it to the Board as soon as it is completed.

☐ Hold my Full License Application until it is within the 90-day time period.

My birthdate is _ Month Day Year

SBM

Signature: [signature] Today's Date: 4/30/2018 (11/3/2017 Month Day Year)

Please return this form with your Full License Application. If you do not submit this form with your Full License Application, your completed Full License Application will be forwarded to the Board for approval at the next Board meeting. Thank you.

273792

RECEIVED
DEC - 6 2017
Board of Registration in Medicine

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

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Type of License ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

SBM 1/16/18

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

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

☒ M.D. ☐ D.O. ☐ PhD ☐ Other degree MPH ☐ Male ☒ Female

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

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

Social Security Number: _____ Date of Birth: ____ ____ ____
Month Day Year

NPI (National Provider Identifier) Number: 1235397506

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

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: - Same - Telephone: _____
Number and Street

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

Business Address: 1894 WALTON AVE Telephone: 718-583-3060
Number and Street

BRONX NY 10453
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: 718-583-3360

Are you applying for licensure through FCVS? ☐ Yes ☒ No SBM 1/16/18

*** The Board will use your Mailing Address for all correspondence**

Date Received: 12/6/17

Check #: 1432317923

Check Amount: $ 600.00

Initials: RF

Pre-medical School **From** **To**

Name: BARNARD COLLEGE Degree: BA Year: 1994 Year: 1998

Street: 3009 BROADWAY City: NYC State: NY

POST-BA, PRE-MED

Name: HUNTER COLLEGE OF CUNY Degree: (NO DEGREE) Year: 1/01 Year: 5/02

Street: 695 PARK AVE City: NYC State: NY

Medical School

Name: SUNY STONY BROOK SOM Degree: MD

Street: HEALTH SCIENCE CENTER LEVEL 4 City: STONY BROOK State: NY

Name: _____ Degree: _____

Street: _____ City: _____ State: _____

Medical School Graduation Date: 05 / 2006
Month Year

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. You must account for all periods of training or postgraduate work from the time you graduated from medical school. Enter month and year only.

From **To**

Facility: BETH ISRAEL MED CENTER PGY Year: 1-3 7/06 6/09

Specialty: FAMILY MEDICINE City: NEW YORK State: NY

Facility: ALBERT EINSTEIN COLLEGE OF MEDICINE/DEPT OF FAMILY MEDICINE/AECOM/MONTEFIORE MED CTR PGY Year: FELLOW 8/09 6/8/11 SBM 6/4/18

Specialty: FAMILY PLANNING City: BRONX State: NY

Facility: SBM 1/6/18 PGY Year: ____ ____/____ ____/____

Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: ____ ____/____ ____/____

Specialty: _____ City: _____ State: _____

Facility: _____ PGY Year: ____ ____/____ ____/____

Specialty: _____ City: _____ State: _____

Examination History

Please contact the appropriate examination entity and have the examination scores sent to you in a sealed envelope. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, FLEX, COMVEX, COMLEX or a state examination.

Examination	Number of attempts	Passed (P) or Failed (F)	
USMLE Step I	1	☒ P	☐ F
USMLE Step II	1	☒ P	☐ F
USMLE Step III	1	☒ P	☐ F
NBME Part I		☐ P	☐ F
NBME Part II		☐ P	☐ F
NBME Part III		☐ P	☐ F
FLEX Component 1		☐ P	☐ F
FLEX Component 2		☐ P	☐ F
FLEX Pre-1985		☐ P	☐ F
NBOME Part I		☐ P	☐ F
NBOME Part II		☐ P	☐ F
NBOME Part III		☐ P	☐ F
COMLEX Level 1		☐ P	☐ F
COMLEX Level 2		☐ P	☐ F
COMLEX Level 3		☐ P	☐ F
COMVEX		☐ P	☐ F
LMCC – Single		☐ P	☐ F
LMCC – Part I		☐ P	☐ F
LMCC – Part II		☐ P	☐ F
State Board Exam	(State of examination and year)	☐ P	☐ F

Hospital Affiliations and Employment

List hospital appointments, in chronological order by month and year where you ever had medical staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

SBM 2/9/18

	From	To
Facility:		
Street:		
Facility		
Street:		
F		
Stree		

1. List other states (abbreviations) where you are currently or have ever had a full license: AL NY SBM 4/16/18
2. a) Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☑ No
3. List Board Certification(s): ABFM
4. List your practice specialt(ies): Family Medicine
5. Have you completed the Opioid and Pain Management training? (See Instructions) ☒ Yes ☐ No
6. Have you completed training to recognize and report suspected child abuse or neglect? ☒ Yes ☐ No
   (Your license will not be processed until you complete the required training – see instructions.)
7. Reason for requesting a Massachusetts medical license: moving to Massachusetts.
8. Name of Facility: private practice TBD or clinic
   Address: Brookline City: Brookline (02446)
9. Anticipated starting date in Massachusetts: 6/1/18
10. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

Under the penalties of perjury, I declare that I have examined this full 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.

D. MD
Signature of Applicant

11 / 3 / 2017
Month Day Year

4/30/18 SBM

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

AUTHORIZATION FOR RELEASE OF INFORMATION, DOCUMENTS AND RECORDS

I, Sarah B. Miller
(type/print your complete name)

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

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

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

Attention: Licensing

Immunity and Release

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

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

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

[signature]
Applicant's Signature

11/3/17 4/30/18 SBM
Date of Signature

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

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

ELECTRONIC HEALTH RECORDS (EHR) PROFICIENCY FORM

Pursuant to M.G.L. c. 112, § 2, an applicant for licensure must demonstrate proficiency in the use of electronic health records (EHR). This is a one-time requirement.

Complete Section 1 (Demonstrating Proficiency) OR Section 2 (Claiming an Exemption) and Sign in Section 3.

SECTION 1. DEMONSTRATING PROFICIENCY

1. I have demonstrated proficiency in the use of EHR in one of the following ways:

☒ Participation in a Meaningful Use program as an eligible professional;
____ Employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital with a CMS Meaningful Use program;
____ Participation as either a Participant or an Authorized User in the Massachusetts Health Information Highway.
____ Completion of 3 hours of a Category 1 EHR-related CPD course that discusses, at a minimum, the core and menu objectives and the Clinical Quality Measures ("CQMs") for Meaningful Use.

SECTION 2. CLAIMING AN EXEMPTION (Exemptions must be claimed each licensing cycle, if applicable. If you are exempted from the EHR proficiency requirement, please select the appropriate exemption.)

2. I am exempt from the EHR Proficiency requirement because I am an applicant

____ who will not be engaged in the practice of medicine as defined in 243 CMR 2.01(4);
____ for an Administrative License;
____ for a Volunteer License;
____ on active duty as a member of the National Guard or of a uniformed service called into service during a national emergency or crisis; or
____ for an Emergency Restricted License.

SECTION 3. SIGNATURE

I, the undersigned applicant, hereby certify that all information included in this EHR Proficiency Form constitutes a true statement made under penalties of perjury.

NAME: O. M_____ DATE: 11/3/2017

Sarah B Miller, MD, MPH

Employment

7/15-present **Assistant Professor/ Visiting Attending,** Department of Family Medicine and Community Health, School of Medicine at Mount Sinai. New York, NY.

7/13-present **Faculty,** Harlem Residency in Family Medicine, Mount Sinai and The Institute for Family Health. New York, NY.

Assistant Fellowship Director, Reproductive Health Fellowship. Reproductive Health Access Project/The Institute for Family Health. Oversee/precept residents, fellows, and providers doing family medicine and procedures.

8/11-present **Contract Physician,** Planned Parenthood of New York City; Planned Parenthood Hudson Peconic, New York; Planned Parenthood South East, Alabama (since 1/2016). Work as clinical service provider. Teach procedure care. **Physician Expert of Vasectomy Services** at PPNYC starting 2017.

8/09-9/14 **Attending Physician and Clinical Instructor, Montefiore Medical Center's Family Health Center**. Bronx, NY. Worked as a family doctor providing full spectrum outpatient care in a Federally Qualified Health Center (through 2011). Precepted medical students and residents. Worked in newborn nursery.

7/06-6/09 **Resident Physician,** Beth Israel Residency in Family Practice, New York City, NY.

6/01-7/02 **Research Assistant,** Center for Urban Epidemiological Studies, New York Academy of Medicine. NYC, NY.

6/98-12/00 **Gardener and Assistant to the Director of North Manhattan Parks,** NYC Department of Parks and Recreation. NYC, NY. Managed district budget; coordinated volunteer projects, community outreach, and special events. Supervised student groups and community volunteers. Performed horticulture duties

Post-Graduate Training

SBM

7/09-6/11 **Family Planning Fellow, Albert Einstein College of Medicine,** Bronx, NY.

7/06-6/09 **Resident Physician in Family Medicine, Beth Israel Residency in Family Practice,** New York City, NY.

Education

9/09-5/11 **Columbia University Mailman School of Public Health.** Heilbrunn Department of Population and Family Health. New York City, NY. Masters of Public Health degree.

8/02-5/06 **School of Medicine, State University of New York at Stony Brook,** New York. Doctor of Medicine.

1/01-5/02 **Hunter College, City University of New York**, New York. Post-Baccalaureate Pre-medical Program.

8/94-5/98 **Barnard College of Columbia University**, New York, NY. BA in English, film studies.

Honors and Awards

2009 **2009 NAPGRC Research Award**, Beth Israel Dept of Family Medicine, NY. Given by the North American Primary Care Research Group in recognition of outstanding family medicine/primary care research.

2009 **John J. Felencki Memorial Award**, BI residency, NY. Award 'for the graduating resident who most inspires us to think outside of our usual framework, using multicultural ideas and multiple healing systems.'

2006-2007 **Board Member, Physicians for a National Health Program**, New York Metro Chapter. Elected position.

2006 **Gold Foundation Humanism Honor Society Inductee**. SUNY Stony Brook School of Medicine.

2004 **Community Citizenship Award, SUNY Stony Brook School of Medicine.** Recognizing outstanding contributions to the off-campus community, especially serving underserved, poor, or minority populations

Publications

Unilateral Absence of Vas Deferens: Prevalence among 23,013 Men Seeking Vasectomy. ***Miller S***, Couture S, James G et al. Int Braz J Urol. 2016 Aug 10

Meeting Women's Needs in a Patient Centered Medical Home. Leighton, L. ***Miller, S.*** Schonberg, D. Phillips S. Family Medicine. 43(10):743-4. 2011

Obesity and the Combined Oral Contraceptive Pill: Efficacy and Effects. ***Miller, S*** et al. Expert Review of Obstetrics and Gynecology. 6(5), 477–480 (2011)

Advocating for Family Planning and Abortion Care in the Patient-Centered Medical Home. ***Miller, S,*** Phillips, S. STFM Messenger. Oct 31, 2010.

Sarah B Miller, MD, MPH

Employment

7/15-present **Assistant Professor/ Visiting Attending,** Department of Family Medicine and Community Health, School of Medicine at Mount Sinai. New York, NY.

7/13-present **Faculty,** Harlem Residency in Family Medicine, Mount Sinai and The Institute for Family Health. New York, NY.

Assistant Fellowship Director, Reproductive Health Fellowship. Reproductive Health Access Project/The Institute for Family Health. Oversee/precept residents, fellows, and providers doing family medicine and procedures.

8/11-present **Contract Physician,** Planned Parenthood of New York City; Planned Parenthood Hudson Peconic, New York; Planned Parenthood South East, Alabama (since 1/2016). Work as clinical service provider. Teach procedure care. **Physician Expert of Vasectomy Services** at PPNYC starting 2017.

8/09-9/14 **Attending Physician and Clinical Instructor, Montefiore Medical Center's Family Health Center**. Bronx, NY. Worked as a family doctor providing full spectrum outpatient care in a Federally Qualified Health Center (through 2011). Precepted medical students and residents. Worked in newborn nursery.

7/06-6/09 **Resident Physician,** Beth Israel Residency in Family Practice, New York City, NY.

6/01-7/02 **Research Assistant,** Center for Urban Epidemiological Studies, New York Academy of Medicine. NYC, NY.

6/98-12/00 **Gardener and Assistant to the Director of North Manhattan Parks,** NYC Department of Parks and Recreation. NYC, NY. Managed district budget; coordinated volunteer projects, community outreach, and special events. Supervised student groups and community volunteers. Performed horticulture duties

Post-Graduate Training

8/09-8/11 **Family Planning Fellow, Albert Einstein College of Medicine,** Bronx, NY.

7/06-6/09 **Resident Physician in Family Medicine, Beth Israel Residency in Family Practice,** New York City, NY.

Education

9/09-5/11 **Columbia University Mailman School of Public Health.** Heilbrunn Department of Population and Family Health. New York City, NY. Masters of Public Health degree.

8/02-5/06 **School of Medicine, State University of New York at Stony Brook,** New York. Doctor of Medicine.

1/01-5/02 **Hunter College, City University of New York**, New York. Post-Baccalaureate Pre-medical Program.

8/94-5/98 **Barnard College of Columbia University**, New York, NY. BA in English, film studies.

Honors and Awards

2009 **2009 NAPGRC Research Award**, Beth Israel Dept of Family Medicine, NY. Given by the North American Primary Care Research Group in recognition of outstanding family medicine/primary care research.

2009 **John J. Felencki Memorial Award**, BI residency, NY. Award 'for the graduating resident who most inspires us to think outside of our usual framework, using multicultural ideas and multiple healing systems.'

2006-2007 **Board Member, Physicians for a National Health Program**, New York Metro Chapter. Elected position.

2006 **Gold Foundation Humanism Honor Society Inductee**. SUNY Stony Brook School of Medicine.

2004 **Community Citizenship Award, SUNY Stony Brook School of Medicine.** Recognizing outstanding contributions to the off-campus community, especially serving underserved, poor, or minority populations

Publications

Unilateral Absence of Vas Deferens: Prevalence among 23,013 Men Seeking Vasectomy. ***Miller S***, Couture S, James G et al. Int Braz J Urol. 2016 Aug 10

Meeting Women's Needs in a Patient Centered Medical Home. Leighton, L. ***Miller, S.*** Schonberg, D. Phillips S. Family Medicine. 43(10):743-4. 2011

Obesity and the Combined Oral Contraceptive Pill: Efficacy and Effects. ***Miller, S*** et al. Expert Review of Obstetrics and Gynecology. 6(5), 477–480 (2011)

Advocating for Family Planning and Abortion Care in the Patient-Centered Medical Home. ***Miller, S*****,** Phillips, S. STFM Messenger. Oct 31, 2010.

Support for Buprenorphine and Methadone Prescription to Heroin-Dependent Patients among New York City Physicians. Coffin P, Blaney, Fuller, Vadnai, ***Miller S***, Vlahov. Amer J of Drug & Alcohol Abuse. 2/2006;32(1):1-6.

Syringe distribution to injection drug users for prevention of HIV infection: Opinions and Practices of Health Care Providers in New York City. Coffin PO, Fuller C, Blaney S, Vadnai L, ***Miller S,*** Vlahov D. Clinical Infectious Diseases 2004 Feb 1; 38(3): 438-41. Epub 2004 Jan 13.

Presentations

· **Office Management of First Trimester Miscarriage.** (Lecture) University of Alabama Dept of Family Medicine. Tuscaloosa, AL. 10/2016.
· **The Well Woman Preventive Visit: Balancing Evidence With Patient Expectations.** (Seminar) with M Simmons, L McLendon. STFM National Meeting. Minneapolis, MN. 5/2016.
· **Vasectomy: A Hands-On Workshop Using the No Scalpel Technique.** (Workshop) with J Curington MD, S Shah MD MPH, N Duke DO. FMEC Meeting. Danvers, MA. 10/2015.
· **Vasectomy Practice and Access: A Discussion.** (Grand Rounds) with Jonathan Stack. Physicians for Reproductive Health. PPFA, NYC. 9/30/2015.
· **Incidence of Chlamydia Trachomatis Infection Among Women Who Have Sex With Women in a Network of Federally Qualified Health Centers in New York** (Poster) with N Hinchcliffe DO and L Prine MD. FMEC Meeting. Danvers, MA. 10/2015
·**Looking Beyond «Intended» vs «Unintended» Pregnancy: Addressing Reproductive Needs Through a Patient-Centered Lens** (Seminar) with C Pierce MD, A Summit MPH. STFM National Meeting. Miami, FL 4/2015
·**Chaotic Lives: Patient, Provider, Optimizing Health and Avoiding Burnout.** (Seminar) With P Lobl PhD. FMEC Regional Meeting. Arlington, VA. 10/2014.
·**Hands-on No-scalpel Vasectomy Training** (Workshop) with J Curington. ARHP Annual Meeting. Charlotte, NC. 9/2014.
·**Expanding Training and Access: A Community-based Reproductive Health Fellowship Model** (Discussion) with L Prine. Association of Reproductive Health Professionals Annual Meeting. Charlotte, NC. 9/2014.
·**Permanent Contraception in the Patient Centered Medical Home: What is the Family Physician's Role?** (Seminar) with R Natarjan and J Conway. FMEC Regional Meeting. Philadelphia, PA. 9/2013.
· **Teaching In-Office Care of First Trimester Pregnancy Complications** (Seminar). FMEC Regional Meeting. Philadelphia, PA. 9/2013.
·**Reversible Contraception.** (Lecture) Southwest University Medical and Nursing School. Cebu, Philippines. 2/2013.
·**Couples Counseling in Family Planning: Including Men in the Contraception Conversation.** (Discussion) FMEC Regional Meeting. Cleveland, OH. 9/2012.
· **Updating the Well Woman "Check-Up."** (Seminar) FMEC Regional Meeting. Cleveland, OH. 9/2012.
· **Where Are All the Men? Strategies to Involve Men in Family Planning.** (Seminar) with G Shih MD MPH. ARHP Annual Meeting. New Orleans, LA. 9/2012.
· **Update on Contraception. (**Grand Rounds Speaker) with L Wang. Jamaica Hospital, NY. 7/26/2012
·**Easy Contraception for Women.** (Lecture) Southwest University Medical and Nursing School. Cebu, Philippines. 2/2012.
·**Ambivalence about Pregnancy: Are They Ready? Results from a Qualitative Study of Providers and the Women they Counsel. (**Research Poster) North American Primary Care Research Group Annual Meeting. Banff, AB, Canada. 11/2011.
·**Patient-Centered Papaya Workshop.** (Workshop) Family Medicine Education Consortium NE Region Meeting. 10/2010.
·**Ambivalence about Pregnancy; A Qualitative Study of Providers and the Women they Counsel.** Fellowship in Family Planning Annual Meeting. Washington, DC. 5/2011.
·**Provider Panel.** Panel member. MSFC. Stony Brook School of Medicine. 1/2011.
· **Family Physicians' Role in Early Abortion Care. (**Grand Rounds) Montefiore Dept Social and Family Medicine. 12/2010.
·**Barriers to IUD insertion.** (Seminar) with M Gold MD and S Phillips, MD, STFM FMEC Meeting. 4/2010
·**Use of Inanimate Models for Early Pregnancy Ultrasound Training.** (Workshop) STFM/FMEC Northeast Region Meeting. Hershey, PA. 10/2010.
·**Uterine Aspiration and Intrauterine Device Placement Using a Papaya Model.** (Workshop) STFM/FMEC Northeast Region Meeting. Hershey, PA. 10/2010.
·**Simplifying Medical Abortion: Home-Use of Mifepristone.** (Seminar) STFM/FMEC NE Region Meeting. 10/2010.
·**Patients' Perspectives on accessing comprehensive reproductive health care.** Miller, Phillips, Gold. MSFC NE. 2/2010.
·**When You're Not the Doctor Your Patient Wanted.** Panel member with Dashawn Taylor, MD and Willie Parker, MD. FFP Psychosocial Workshop Seminar. San Francisco, CA. 3/2010.
·**Updating the Check Up (seminar)** with R Lesnewski, MD, STFM/FMEC NE Meeting 2009
·**The Periodic Exam: Men and Women** with R Lesnewski, MD, STFM National Meeting 2009
·**Bringing Group Visits for Residency Practices** seminar with W Barr, STFM Annual Meeting 2009
·**Everything About Contraception and Abortion You Don't Learn in Medical School**, (Seminar) with S. Morrison, MD. Hunter College AMSA pre-med event. New York, NY. 11/2008.

·**Office Management of Miscarriage** (Poster) with A Luddy, L Prine. Presented at STFM NE regional meeting 2008
·**The Well Woman Exam Revisited** (Grand Rounds), with H MacNaughton, Beth Israel Family Medicine Dept 4/2007
·**Medical Abortion Regimens** with J Wu, Medical Students For Choice Annual Meeting, St. Petersburg, Fl 3/2007
·**Group Prenatal Visits to Teach Obstetrics to Family Medicine Residents** (Seminar) with M Levin, STFM 2007 Northeast Region Meeting, Pittsburgh, PA 10/2007
·**Oral Contraceptive Pills—Over the Counter?** (Breakfast Discussions) with L Prine, MD, STFM Annual Meeting, Chicago, IL, 4/2007. With H MacNaughton, STFM 2007 Northeast Region Meeting, Pittsburgh, PA 10/2007
·**The Well Woman Exam**, (Seminars) with R Lesnewski and S Rubin, Society of Teachers of Family Medicine (STFM) Annual Meeting, Chicago, IL, 4/2007. With H MacNaughton, STFM 2007 NE Region Meeting, Pittsburgh, PA 10/2007

Projects in Progress

·**Ambivalence about Pregnancy Planning: A Qualitative Study of Providers and the Women they Counsel.** Qualitative research project. IRB approved. Manuscripts in progress.

Healthcare Advocacy/ Volunteer Activities

Physican Director of Vasectomy Services. Planned Parenthood of New York City, 1/2017 to present.
Medical Advisory Board Member. World Vasectomy Day 2014, 2015, 2016.
Clinician Panel Member. National Institute for Reproductive Health/Reproductive Health Access Project screening HBO special Abortion Stories Women Tell. NYU Law School New York, NY. 10/2016
NSVI Vasectomist, Cebu, Philippines. Traveled to the Philippines to provide «no scalpel» vasectomies and take part in medical-surgical mission with non-profit No Scalpel Vasectomy International. 2012, 2013, 2015, 2016
Clinician Panel Member. National Institute for Reproductive Health/Reproductive Health Access Project/Law Students for Reproductive Justice screening Trapped. NYU Law School New York, NY. 3/2016
Panel Member. New York County Lawyer's Association's Committee on Women and Law event. New York, NY. 4/2015
Volunteer. People's Medical Relief. Coney Island, New York. Medical tent and outreach after Hurricane Sandy. 11/2012
Delegate. Annual Congress of Delegates. New York State Academy of Family Physicians. Troy, NY. 6/2014
Physician Prescriber/Educator. Fordham University Law Students for Reprodictive Justice. New York City. 10/2012-2014
Mentor, Montefiore Health Opportunities Program (MonteHOP), Bronx, NY. 6/10-8/11
Speaker. Rally for Women's Health. Foley Square, New York. 2/2011.
Fellow. Leadership Training Academy. Physicians for Reproductive Health. Eight-month, intensive program to prepare select physicians to become lifelong leaders in reproductive health advocacy. 9/10-4/11.
Speaker. With D Schonberg, S Phillips, M Gold. Research-Based Health Activism and Reproductive Health. 11/10.
Panel member. Birthing Choices Panel Current Issues, Controversies and Updates. Sexual and Reproductive Health Action Group. Mailman School of Public Health. New York, NY. 4/10
Speaker. With S Phillips MD. Being a Physician-Advocate. NYU medical student advocacy group. 3/2010.
Speaker. With S Phillips. Organizing for America-Brookhaven chapter informational meeting: "Women's Health Care and Health Insurance Reform: Why Women in particular are vulnerable under the present system." Setauket, NY. 11/09.
Co-coordinator, Streetside Health Project, New York City. Provided vaccines and health referrals at needle exchanges and soup kitchens. Promoted harm reduction awareness among medical student volunteers. 6/2001-2/2002

Professional Memberships

American Academy of Family Physicians, Association for Reproductive Health Professionals, The American Society for Colposcopy and Cervical Pathology, National Abortion Federation, National Physicians Alliance, Physicians for Human Rights, Physicians for a National Health Program, Physician for Reproductive Health, Society of Family Planning, Society of Teachers of Family Medicine, Family Medicine Education Consortium

License/Certification

New York State and Alabama Medical Licensure
American Board of Family Medicine Certified
ACLS, BLS certified.
DEA X waiver

Languages

Medical Spanish (conversant), French (basic)

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

MALPRACTICE HISTORY REQUEST FORM

Applicant's Instructions: Please list the names of your liability carriers and send a signed copy of this form to each of these liability carrier(s). You must include all of your liability carriers from the time your first full license was issued in any state. Do not include your time in a postgraduate training program unless you held a full license OR you were named in a malpractice case during that period. This form must be returned to the Board with your license application.

Liability Carrier's Instructions: Please submit to the applicant a malpractice history report on letterhead, which includes the following information:

Note: I have never had individual malpractice/liability insurance Coverage has been supplied Through employer

1. dates of policy coverage;
2. whether the applicant has any claims history;
3. if the applicant does have a claims history, please include:
   a. the name/initials of the claimant(s);
   b. nature and date of claim(s);
   c. whether the claim is pending or closed;
   d. amounts paid on the applicant's behalf, if any; and
   e. final disposition.
4. If your company's name has changed, please provide any former company names.

If the applicant has a claims history, for each claim please provide a copy of the complaint, notice of intent to file a claim letter, or other claim letter and a copy of the final judgment, settlement and release or other final disposition of each claim. The information should be sent directly to the Board.

Liability Carrier: FTCA Through PHS Act. From: 10 / 2011 To: current
City: 1-F00000647-11-09 State: Federal Policy #: Grant # H80CS00708

Liability Carrier: New Hampshire Ins Company From: 1 / 2011 To: current
City: Pittsburg National Union Fire Ins State: PA. Policy #: 23841 | 19445
Montefiore.

Liability Carrier: Hospital Insurance Company From: 7 / 2009 To: 9 / 2014
City: White Plains State: NY Policy #: 700000 6 7 HP
09 - 10 - 11 - 12 - 13 - 14 -

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy #: _____

Liability Carrier: _____ From: ____/____ To: ____/____
City: _____ State: _____ Policy #: _____

Applicant's signature: _____ 5 / 24 / 18 (originally 11/3/1
Date

Print Name: Sarah R. Miller

Address: _____

City: _____ State: _____ Zip code: _

Additional forms available at the Board's website at www.mass.gov/massmedboard.

Sealed Envelope

Initials: MJ

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

MEDICAL EDUCATION VERIFICATION – FORM A

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification. **Please note: Fourth year medical students must include the letter to the medical school registrar and Form B.**

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: _____ Date of Birth: _____

Name (Please type or print): Miller (Last Name) Sarah (First Name) B (Middle Initial)

Other Name(s) (Please type or print.): n/a

Name of Medical School: Stony Brook School of Medicine

Address: HSC Level 4 Room 149 City: Stony Brook State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete Form A. For fourth year medical graduates, please complete Form B after the student completes the degree requirements. Please include a copy of the official transcript (which indicates courses taken, dates and hours of attendance, scores, grades, or evaluations) and return to the applicant in a sealed envelope. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above-named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Barnard College

Undergraduate School Address: 3009 Broadway New York, NY 10027

Enrollment and Participation:

Our records indicate that Miller, Sarah
(Print the applicant's name): (Last name) (First name) (Middle Initial)

attended our medical school for a total of 152 weeks (must be included) of continuous medical education on the following dates from 08/15/2002 to 05/19/2006
month/day/year month/day/year

This applicant:

Check one: ☑ **was awarded the** degree of M.D. on 05/19/2006
month/day/year

☐ **will be awarded** the degree of _____ on ____/____/____
(Form B must also be completed and returned directly to the Board.) month/day/year

☐ **was not awarded** a degree because: _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Was the medical school training more than four (4) years for U.S. graduates or 6 years for international medical graduates, or did the applicant take any leaves of absence (i.e. for research, public service, participation in an M.D./Ph.D. program) or for any "personal reasons"?		
2. Was the applicant ever placed on probation or remediation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

Please provide a detailed explanation for any of the above questions _____

_____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized.)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Caroline M Lazzaruolo

Print Name: Caroline Lazzaruolo

Title: Registrar

Date: 11/7/2017 Telephone: (631) 444-9547

E-mail address: Caroline.Lazzaruolo@Stonybrook medicine.edu

This form must be stamped with the institutional seal or notarized. Please return to the applicant with the medical school transcripts in a sealed envelope with the signature of the Dean or the seal of the medical school affixed on the back of the envelope. Thank you.

Seal Verified
DATE: 12·7·17
INITIALS: MJ

Sealed Envelope

Initials: MJ

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

INSTRUCTIONS TO THE APPLICANT: This form must be signed by a physician legally authorized to practice medicine in the United States. Someone who has known you for at least one year and is not a relative should execute this statement. The Board of Registration in Medicine prefers statements from physicians licensed to practice in Massachusetts. **The form must be notarized by a U.S. Notary Public**.

PHOTOGRAPH

cent 2 x 2 color
. Black and white
s will not be accepted.

gn your name in the
a **U.S. Notary Public**.

CERTIFICATION OF MORAL AND PROFESSIONAL CHARACTER

This certifies that I have been personally acquainted with the physician named below:

Sarah B Miller MD MPH
(name of applicant)

for 13 years. I believe that the above named physician is of good moral character and worthy of confidence and recommend him/her to the Massachusetts Board of Registration in Medicine.

Signature of applicant

I certify that the photograph above is a genuine likeness of the maker of the signature above.

Signature of Notary

4/20/2023
My commission expires

BRET AARON BIRMAN
Notary Public, Commonwealth of Massachusetts
My Commission Expires April 20, 2023

Signature of Certifying Physician

254302 — License Number
MA — State

Margee Louisias MD MPH
Type or print name clearly

Address: 75 Francis Street

City: BOSTON State: MA Zip: 02115
Telephone: (617) 732 9850
Date: 11/21/2017

***Instructions to the certifying physician**: Please answer every question, date this form, and return it to the applicant in a sealed envelope with your signature across the seal.*

Seal Verified
DATE: 12.7.17
INITIALS: MJ

Sealed Envelope

Initials: MJ

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 11/3/17

Print or Type Name: Sarah B Miller

Name and Address of Institution: Beth Israel Residency in Urban Family Practice
16 E 16th St
New York, NY 10003

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**.

Name of Institution: Mt Sinai Downtown Family Medicine Residency

Name of Institution, if different when applicant attended: Beth Israel Residency in Urban Family Practice.

Verification for: Sarah B. Miller
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Internship	PGY1	Family Medicine	7/01/06	6/30/07	Yes	ACGME
Residency	PGY2-3	Family Medicine	07/01/07	6/30/09	Yes	ACGME
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: Sarah B Miller, MD

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **If you answer "yes" to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: 

Print Name: Andreas Cohrssen

Academic Title: Associate Professor mssm, Residency Program Director.

Telephone: (212) 206-5214 Today's Date: 11/15/17

E-mail address: acohrssen@institute.org

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified
DATE: 12.7.17
INITIALS: MJ

Sealed Envelope

Initials: KM

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: D. MD Date: 1/16/18

Print or Type Name: Sarah B Miller MD MPH

Name and Address of Institution: Marji Gold MD, Director Family Planning Fellowship
Department of Family and Social Medicine
3544 Jerome Ave, Bronx, New York 10467

TO BE COMPLETED BY PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. Name of Institution: Albert Einstein College of Medicine/Dept of Family and Social Medicine

Name of Institution, if different when applicant attended: _____

Verification for: Sarah Miller
(Print applicant's name)

Program Type (Report internships, residencies, and fellowships separately.)	**PGY** (1,2,3,4, etc.)	**Department or Type of Specialty Training** (Use one section per department/specialty. If the department/specialty was a "rotating" or "transitional" program, please provide a schedule of rotations.)	**Dates Attended** (Month/Day/Year) **FROM**	**TO**	**Completed** (Yes/No/In Progress)	**Accredited by** (ACGME, AOA, RSC, or not accredited)
Fellowship	pgy4-5	Training in family planning	7/1/09	6/30/11	yes	no
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		
			/ /	/ /		

Report incomplete training levels (years) separate from those that were successfully completed. If the training level (years) is currently in progress, report the expected completion date in the "TO" field.

APPLICANT'S NAME: Sarah B Miller MD MPH

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. **If you answer "yes" to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her postgraduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

COMMENTS: _____

Certification: I hereby certify that the above information is an accurate account of this individual's record and is true and correct.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: _____

Print Name: Mafji Gold, MD

Academic Title: Professor of Family and Social Medicine

Telephone: (212) 366-9320 Today's Date: 1/22/18

E-mail address: marji.gold@einstgien.yu.edu

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

ELBA IRIS CARPIO
Notary Public, State of New York
Qualified in Bronx County
No. 01CA6070198
My Commission Expires Feb. 25, 2018

Seal Verified
Initials: _____

State of Alabama
Medical Licensure Commission
James E. West, M.D., Chairman/Executive Officer
Karen Silas, Executive Assistant

11/27/2017 Sealed Envelope

Initials: MJ

Massachusetts Medical Board
200 Harvard Mill Square Suite 330
Wakefield, MA 01880

VERIFICATION OF ALABAMA MEDICAL LICENSURE

Name of Licensee (as it appears in our Records)
Sarah B. Miller

Date of Birth:
License Number: **MD.34776**
Current Status: **Active**
Date Issued: **01/01/2016**
Basis of License: **USMLE/NY**
Expiration Date: **12/31/2018**
Medical School: **State University of New York at Stony Brook Health Science Cente**
Location: **Stony Brook**
Date From/To: **8/02-5/06**

Disciplinary Actions:

[X] No

[ ] Yes, visit Public Actions at www.albme.org for documents.

Signature: James E. West, M D

James E. West, M.D.
Chairman
Medical Licensure Commission of Alabama

To expedite the verification process, the above is the standard format used by the Medical Licensure Commission of Alabama. Verification information can also be obtained by accessing our website at http://www.albme.org.

P.O. Box 887 • Montgomery, AL 36101-0887
848 Washington Avenue • Montgomery, AL 36104-3839
334-242-4153 • www.albme.org

Seal Verified
DATE: 12·7·17
INITIALS: MJ

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
DIVISION OF PROFESSIONAL LICENSING SERVICES
89 WASHINGTON AVENUE
ALBANY, NEW YORK 12234

This is to certify that according to the records of the Division of Professional Licensing Services, New York State Education Department Albany, New York, MILLER SARAH BOZOGAN
was issued license/certificate number 252627 for the practice of MEDICINE on 04/02/2009.

Our records also indicate the following information:
Date of birth:
School attended: SUNY STONY BROOK-HEALTH
Date of graduation: 05/19/06
Degree earned: MD

Program was acceptable in accordance with the NYS Regulations of the Commissioner of Education. Requirements met at the time of licensure.

Basis of licensure:

DATE	FLEX1	NBME1	USML1	NBME2	FLEX2	USML2	NBME3	USML3	OTHER
12/08								00098	OOSMA
12/05						00099			
06/04			00093						

EXMS TAKEN=03
A license is valid during the life of the holder unless revoked, annulled or suspended by the Board of Regents. A licensee must register periodically with this Department to practice in this state.

Currently Registered: YES Reg period ends: 08/31/18
Address: 454 W 152ND ST APT 42
NEW YORK NY 10031-0000
Disciplinary information: No charges have been preferred against this licensee
Comments:

I, Cathy Hanczaryk, Principal Clerk, Division of Professional Licensing Services of the New York State Education Department, do hereby state that as Principal Clerk of said Division, I have legal custody of the official records of the Division of Professional Licensing Services and to the best of my knowledge, the aforesaid information is true and correct.

SEAL

Cathy Hanczaryk 12/07/17
Office Assistant Three

Seal Verified
Initials: KM

4/30/18 SBM

PRINT NAME: Sarah B. Miller DATE: 4/3/17

FULL LICENSE APPLICATION SUPPLEMENT

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 5-11.

QUESTIONS		YES	NO
1.	While enrolled in college, medical school, graduate school or postgraduate training were you ever the subject of any disciplinary action? (This includes action that was formal or informal, oral or written, voluntary or involuntary. A confidentiality agreement does not absolve you of your requirement to answer this question.)		
2-A.	Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B.	Have you ever been placed on probation or remediation by a medical school, graduate school or any postgraduate training program?		
3.	If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?		
4.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of or found to have cheated or engaged in improper conduct during an examination?		
5.	Have you ever been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6.	Have you ever surrendered a license to practice medicine or any professional license or has your license or certificate ever been revoked? (You do not need to report a lapsed license.)		
7.	Have you been denied American Board of Medical Specialties or American Board of Osteopathic Medicine certification or has your certification ever been suspended or revoked?		
8-A.	Are you aware of any pending investigation or inquiry into your professional conduct by any entity or are any disciplinary charges pending against you?		
8-B.	Since your completion of postgraduate training, has any disciplinary action ever been taken against you? (A confidentiality agreement does not absolve you of your requirement to answer this question.)		

4/30/18 SBM

PRINT NAME: Sarah B. Miller DATE: ~~4/3/17~~

		YES	NO
9-A.	Have you ever relinquished any medical staff membership or association with a health care facility?		
9-B.	Has your medical staff membership, medical privileges, medical staff status or association with a health care facility ever been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee, administration or governing board?		
9-C.	Have you ever withdrawn an application for hospital privileges or appointment, or have you ever been denied medical staff membership, advancement in medical staff status or association with a health care facility, or has such denial been recommended by a medical staff committee, administration or governing body?		
10.	Have you ever been charged with any criminal offense? (You must report being arrested, arraigned, indicted or convicted, even if the charges against you were dropped, filed, dismissed, expunged or otherwise discharged. A charge of operating under the influence or its equivalent is reportable. A medical malpractice claim is a civil, not a criminal, matter and need not be reported for purposes of this question.)		
11.	Has your privilege to manufacture, distribute, administer, possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever had an application for membership as a participating provider denied by any third-party payor, Medicare or Medicaid (any state) or have you ever been the subject of any termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid (any state) or have you ever been restricted from receiving payments from any third-party payor, Medicare, Medicaid (any state)?		
14-A.	Has any medical malpractice claim ever been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
14-B.	Has any lawsuit, other than a medical malpractice suit, ever been filed against you which is related to your practice of medicine or has such a suit been settled, adjudicated or otherwise resolved?		

4/30/18 SBM

PRINT NAME: Sarah B. Miller DATE: 11/3/17

CONFIDENTIAL INFORMATION

If answering "yes" to any of the questions, provide details on the supplemental pages for questions 15 - 17. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application; it means recently enough to impact one's functioning as a physician.

		YES	NO
15.	Do you have a medical or physical condition that currently impairs your ability to practice medicine?		
16.	Have you engaged in the use of any substance(s) with the result that your ability to practice medicine is currently impaired?		
17.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		

If you have a substance use disorder or mental or physical health diagnosis that impacts your ability to practice medicine, the Board encourages you to seek assistance voluntarily and to abide by any recommendations of your health care provider.

When the Board receives notice of a substance use disorder, its primary mission is to protect the public; however, the Board also seeks to ensure successful rehabilitation through the physician's participation in approved treatment programs and supervised structured aftercare. Similarly, when the Board receives notice of a mental health or physical health diagnosis that impacts a physician's ability to practice, the Board needs to ensure that the physician can practice medicine safely.

In regard to issues of physician impairment, whether the impairment is caused by a substance use disorder, or a mental or physical health diagnosis, the Board works cooperatively with the Massachusetts Medical Society's Physician Health Services (PHS) and encourages physicians to contact PHS to determine what services may be available to them in order to ensure their safe practice of medicine. Please call PHS at (781) 434-7404.

If your responses to Questions 1-17 change while your application is pending, you must immediately notify the Board of the new information.

6/4/18 SBM
4/30/18 SBM

PRINT NAME: Sarah B. Miller DATE: 4/30/18

CERTIFICATIONS

- Pursuant to M.G.L. c. 112, § 2 and 243 CMR 2.07(15), I certify that I will not charge to or collect from a Medicare beneficiary more than the Medicare "reasonable charge" for services, in compliance with Chapter 475 of the Acts of 1985. (*Note:* Signing this certification does not imply that you will participate in the Medicare program).
- Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes that are required under law. (*Note:* This applies even if you reside out of the state or out of the country.)
- Pursuant to G.L.c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L.c. 119A relating to withholding and remitting child support.
- Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children.
- I will read the Board's regulations, 243 CMR 1.00 through 3.00.

I certify under the penalties of perjury that all information on this form, and all attached pages, is true, to the best of my knowledge.

Applicant's Signature: [signature] Date: 4/30/18

[signature] 6/4/2018 SBM

Mulero, Francee (MED)

From: Sarah Miller
Sent: Thursday, September 20, 2018 11:36 AM
To: BORIM MA Profiles (MED)
Subject: Correct profile for Sarah B Miller. MD license# 273792

Hello,

There is an error in the post graduate training listed on my profile. Although I am good at laceration repair, I have no training in facial plastic surgery.

Incorrect: Albert Einstein College of Medicine/Dept of Family and Socail Medicine, Fellow:Facial Plastic Surgery (7/1/2009 - 6/30/2011)
Please correct to: Albert Einstein College of Medicine/Dept of Family and Socail Medicine, Fellow:Family Planning (7/1/2009 - 6/30/2011)

Reference: http://profiles.ehs.state.ma.us/Profiles/Pages/PhysicianProfile.aspx?PhysicianID=123843
MA lic# 273792
NPI 1235397506

Also, I DO accept medicaid, AM accepting new patients, I speak Spanish, and I have a hospital affiliation (in NY): Mt Sinai Hospital.

Please let me know if you need any additional information in order to corrent my profile.

Thank you,

--
Sarah B Miller
Family Physician
917-362-8512

273792

The Commonwealth of Massachusetts

William Francis Galvin
Secretary of the Commonwealth
One Ashburton Place, Boston, Massachusetts 02108-1512

Certificate by Regulatory Board

In compliance with General Laws, Chapter 156C/108A the, Board of Registration in Medicine hereby certifies
(name of board)

that in connection with the formation/registration of: Northeast Vasectomy and Family Planning PLLC
(name of company/partnership)

a professional limited liability company/limited liability partnership formed to render PHYSICIAN services
(type of service)

the below listed members/partners are duly licensed or admitted to practice the profession listed above.

Member/Partners	Addresses
Sarah B. Miller	111 HARVARD STREET BROOKLINE, MA 02446

Candace Lapidus Sloane, MD

Signed by: _____,
(chairman/clerk of the regulatory board)

on this 15th day of November, 2018.

Delete any inapplicable language.