Application #: 273184
Date of Issue: _____

REDACTED COPY

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

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.

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

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

MOORE NICOLA LOUISE

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

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☐ 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.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: LONDON ENGLAND United Kingdom
City State/Province/Territory Country if not USA

Home Address: _____

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

Business Address: _____
Number and Street

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

Business Telephone: ___ ___ ___ ext. _____ Home Telephone: ___ ___ ___

Preferred Mailing Address: ☐ Business Address ☒ Home Address

ck# 2612
$600
1. 3/15/04

PRINT NAME: MOORE, NICOLA LOUISE

Pre-medical School

Facility: Yale University Degree: BA From 8/72 To 12/76
Street: 110 College Street City: New Haven State: CT

Facility: Yale School of Medicine Degree: MPH 9/80 6/82
Street: 333 Cedar Street City: New Haven State: CT

Medical School

Facility: Albert Einstein Coll of Med Degree: MD From 8/95 To 6/99
Street: 1300 Morris Pk Ave City: Bronx State: NY

Facility: Degree: __/__/__ __/__/__
Street: City: State:

Date of medical school graduation: 6/3/99

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

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. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Family Medicine
Facility: Highland Hospital Position: Resident From 7/99 To 9/22/02
Street: 885 South Ave City: Rochester State: NY

Facility: Repro Health, Highland Hospital Position: Fellow 9/23/02 6/30/03
Street: 1000 South Ave City: Rochester State: NY

Facility: Position: __/__/__ __/__/__
Street: City: State:

Facility: Position: __/__/__ __/__/__
Street: City: State:

Facility: Position: __/__/__ __/__/__
Street: City: State:

PRINT NAME: MOORE, NICOLA LOUISE PAGE 3 OF 3

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active 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.

			From	To
Facility: Univ of Rochester	Position: Instructor		09/02	09/03
Street: 885 South Ave	City: Rochester	State: NY		
Facility: Strong Mem Hosp	Position: Assoc. Attdg		12/02	12/04
Street: 301 Elmwood Ave	City: Rochester	State: NY		
Facility: Highland Hospital	Position: Assoc Attdg		1/03	12/04
Street: 1000 South Ave	City: Rochester	State: NY		
Facility: Univ of Rochester	Position: Clin Instructor		10/03	9/04
Street: 885 South Ave	City: Rochester	State: NY		

+ See attached

1. List other states (abbreviations) where you are currently or have ever been licensed: NY
2. Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
3. List Board Certification(s): Family Practice Certification date: 07/04

   Certification date: ___/___/___
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Moved to MA to stay with elderly mother. ANTICIPATED WORK IN MASSACHUSETTS -
6. Name of Facility: ?
7. Address: City:
8. Anticipated starting date in Massachusetts: 9/05

Affidavit of Applicant

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

Nicola Louise Moore 9/11/04

Signature of Applicant Date

Rev: 10/21/2002

Westside Health Services 09/02 - 06/03
175 Lyell Ave Rochester NY

Mpilo Hospital Expatriate Orientee
Bulawayo, Zimbabwe 11/03 - 7/04

Nicola Louise Moore 9/11/04

223154 11/15/05 BZ

11/18/05 S2 284

Mass.Gov • online services • agencies • elected officials • help

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Massachusetts Board of Registration in Medicine Physician Profile

NICOLA L MOORE MD

I. Physician Information

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

License Status:	Active
License Issue Date:	02/16/2005
Accepting New Patients:	~~No~~ Yes
Accepts Medicaid:	~~No~~ Yes
Primary Work Setting:	~~None Reported~~ Clinic
Business Address:	~~1 Richdale Avenue Apt. 15 CAMBRIDGE, MA 02140~~ Outer Cape Health Services 49 Harry Kemp Way Provincetown, MA 02657
Phone:	~~(617) 894-0205~~ (508) 487-9395
Translation Services Available:	None Reported
Insurance Plans Accepted:	~~None Reported~~ Many
Hospital Affiliations:	~~None Reported~~ Beth Israel Deaconess Medical Center

II. Education & Training

Medical School:	Albert Einstein College of Medicine Yeshiva Univ
Graduation Date:	1999
Post Graduate Training:	6/21/1999-6/28/2000 - Univ. of Rochester - Intern: Family Practice 6/29/2000-9/22/2002 - Univ. of Rochester - Resident: Family Practice 9/23/2002-6/30/2003 - University of Rochester - Fellow: Family ~~Practice~~ Planning 2/7/2005-5/3/2005 University of Liverpool - Diploma in Tropical Medicine and Hygiene

III. Specialty

Area of Specialty:	Family Practice
ABMS Board Certification:	Family Practice

IV. Honors and Awards

Nicola Louise Moore
email:

United States Address

EDUCATION:

UNIVERSITY OF ROCHESTER	Fellowship in Family Planning	2003
UNIVERSITY OF ROCHESTER	Residency in Family Medicine	2002
ALBERT EINSTEIN COLLEGE OF MEDICINE	Doctor of Medicine	1999
YALE UNIVERSITY	Master of Public Health	1982
YALE UNIVERSITY	Bachelor of Arts	1976

ACADEMIC AND HOSPITAL APPOINTMENTS:

10/03 present **CLINICAL INSTRUCTOR, Department of Family Medicine, School of Medicine and Dentistry, University of Rochester, Rochester, New York**

1/03-12/04 **ASSOCIATE ATTENDING WITH ADMITTING PRVILEGES, Highland Hospital, Rochester, New York**

12/02-12/04 **ASSOCIATE ATTENDING WITH ADMITTING PRIVILEGES, Department of Pediatrics, Strong Memorial Hospital, Rochester, New York**

9/02-9/03 **INSTRUCTOR IN FAMILY MEDICINE, School of Medicine and Dentistry, University of Rochester, Rochester, New York**

11/00-6/02 **ASSOCIATE IN FAMILY MEDICINE, School of Medicine and Dentistry, University of Rochester, Rochester, New York**

WORK EXPERIENCE:

10/04-02/05 Medicins Sans Frontieres – Holland, Lor, Western Upper Nile, South Sudan
DOCTOR. Provided outpatient, and inpatient services in remote rural area: tropical and parasitic diseases, tuberculosis, sexually transmitted diseases, malnutrition, wound management, obstetrics, abortion management.

11/03-7/04 Ministry of Health and Child Welfare, Bulawayo, Zimbabwe
GOVERNMENT MEDICAL OFFICER – ORIENTEE. Provided clinical services in large referral hospital while receiving orientation to local protocols for medicine, pediatrics, obstetrics, gynecology and surgery.

9/02-6/03 Westside Health Services – Brown Square Health Center, Rochester, New York
FAMILY PRACTICE PHYSICIAN. Full spectrum family practice, including obstetrics, in inner-city community health center and community hospital.

9/02 6/03 Department of Family Medicine, University of Rochester, Rochester, New York
FAMILY PLANNING CLINICAL AND RESEARCH FELLOW. Reproductive health services, including family planning, abortion/pregnancy completion, sexually transmitted disease management in multiple public and private outpatient facilities.

7/99-9/02 **Highland Hospital and Brown Square Health Center, Rochester, New York**
FAMILY MEDICINE RESIDENT.
- Primary care - inner-city community health center, 50% Hispanic; 90% Medicaid.
- Obstetrics/Gynecology - advanced training, including 6 months of inpatient obstetrics, large continuity OB practice.
- Inpatient Services - community hospital, including clinical care, teaching and supervision
- Emergency care - pediatric, surgical and medical ED services

8/92-6/94 **Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, New York**
PROJECT DIRECTOR, TUBERCULOSIS INITIATIVE. Coordinated multiple tuberculosis-related activities for facilities associated with an urban medical center and its medical school affiliate (including hospitals, community health centers, methadone maintenance treatment facilities and a prison health service).
- Established and managed directly observed therapy program (20,000 visits/year) to serve pediatric and adult TB patients (80% HIV-infected).
- Established, with prison staff and health department and provider representatives, new systems for coordinating post-release care of inmates with tuberculosis.

1/87-7/92 **Montefiore Medical Center, Moses Division, Bronx, New York**
DIRECTOR OF OPERATIONAL SERVICES. Hired to improve support and ancillary services of 750 bed hospital.
- Established two support service departments; supervised 25 employees; responsible for $8 million supply and $1 million capital budgets.
- Redesigned major non-clinical services for 35 inpatient units: scheduling and coordination of diagnostic procedures; transport of patients; acquisition and distribution of supplies.
- Coordinated operations aspects of all inpatient facilities renovations.

6/81-12/86 **Arthur D. Little, Inc., Health Care Management, Cambridge, Massachusetts**
CONSULTANT. Managed consulting projects for government, private and public health care clients. Provided planning, technical assistance, operations review for clinics, hospitals, HMOs and vendors of health care products.

10/79-6/81 **Yale University School of Medicine, Department of Epidemiology and Public Health, New Haven, Connecticut**
ASSISTANT IN RESEARCH. Evaluated changes in quality of care of renal stone patients in Connecticut community hospitals: abstracting and coding medical records data, data analysis and report preparation.

10/78-5/79 **University of Connecticut Health Center, Department of Nuclear Medicine, Farmington, Connecticut**
RESEARCH ASSISTANT. Animal experimentation with radioactive tracers for diagnostic scanning.

5/77-2/78 **Yale Psychiatric Institute, New Haven, Connecticut**
PSYCHIATRIC AIDE. Coordinated treatment plans and daily activities for 20 schizophrenic adolescents in milieu therapy setting.

RECENT VOLUNTEER EXPERIENCE:

3/03-5/03 **Mpilo Central Hospital, Bulawayo, Zimbabwe**
Provided obstetrical and gynecological care in large referral hospital. Provided ante-natal, delivery and post-natal care and performed completion of incomplete abortions. Trained attending physicians and housemen in related procedures. Sponsored by Rotary International.

2/01-3/01 **Mondaña Clinic, Napo Province, Ecuador**
Provided primary care and participated in child survival outreach project in Amazon jungle.

6/00-11/00 **Finger Lakes Migrant Health, Ontario County, New York**
Provided screening, vaccinations and primary care services to laborers and their families at farm worker camps.

9/95-6/96 **New York Harm Reduction Educators, Inc. and Citiwide Needle Exchange, Bronx, New York**
Participated in street-based needle exchange programs for IVDUs. Provided clean needles, safe-sex and safe-injection education and medical and social service referrals. Organized on-going medical student participation in exchange and in influenza and pneumococcal vaccination programs; recruited and trained students.

HONORS AND AWARDS

The Highland Hospital Family Medicine Women's Health Care Award for Outstanding Accomplishment in the Field of Women's Health, 2002.

RECENT CONTINUING MEDICAL EDUCATION (examples)

7/03 **Johns Hopkins Hospital, Baltimore**
Preceptorship in Ultrasound

2/03 **Doctors of the World, New York**
Human Rights Clinic Training.

LICENSING AND CERTIFICATION

Board Certified, American Board of Family Practice
New York License number 219226
ALSO
NALS
ACLS

LANGUAGES

Spanish, medical and basic

REFERENCES

Available on request.

Commonwealth of Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

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.

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: Nicola Louise Moore Date of Birth ___

Print or Type Name: MOORE (Last name) NICOLA (First Name) L (Middle Initial) Social Security No: ___

Other Name(s) ___ (Please type or print name(s))

Name of Medical School: Albert Einstein College of Medicine

Address: 1300 Morris Park Ave City: Bronx State or Province: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

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: Yale University

Undergraduate School Address: New Haven, CT

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2004 SEP 23 PM 3:12
BOARD OF REGISTRATION IN MEDICINE

(Continued on page 2)

[redacted] 595

Enrollment and Participation: Our records indicate that

Medical Education Verification - 2

Moore	Nicola	L.
(Last name)	(First name)	(Middle initial)

(type or print the applicant's name):

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 16 / 95	06 / 19 / 96	06 / 02 / 98	05 / 24 / 99
	09 / 03 / 96	05 / 16 / 97	/ /	/ /
	06 / 16 / 97	05 / 31 / 98	/ /	/ /

The applicant attended 176 **total weeks (must be included) of continuing on-campus education, not less than 32 weeks in each academic year**

check one

☒ was awarded a degree in Doctor of Medicine on (month/day/year) 06 / 03 / 1999

☐ was NOT awarded degree. Please explain reason(s)._____

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. Did the applicant take any leaves of absence or breaks from his/her medical education?		
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?		

COMMENTS:_____

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: [signature]

Print Name: Sarifa Switzer

Title: Registrar

Date: 09 / 21 / 04 Telephone: (718) 430-2102

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Seal Verified

DATE: 9/23/04

INITIALS: RF

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

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: Nicola Louise Moore. Date: Aug 13, 2004

Print or Type Name: NICOLA LOUISE MOORE

Name of Institution: FAMILY MEDICINE RESIDENCY, Highland Hospital/ University of Rochester

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of Rochester/ Highland Hospital Family Med.

If name of institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Nicola L. Moore, MD (Print applicant's name) participated in the following program:

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	PGY1	Fam med	6/21/99	6/28/00	✓	ACGME
	PGY2	"	6/29/00	6/27/01	✓	ACGME
	PGY3	"	6/28/01	9/22/02	✓	ACGME

(Continued on page 2)

APPLICANT'S NAME: NICOLA LOUISE MOORE

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **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 post-graduate 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?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

CHRISTINE BAIR
Notary Public, State of New York
AFFIX INSTITUTIONAL SEAL HERE
Qualified in Monroe County
Commission Expires July 29, 2010

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

Program Director's Signature: _____

Print Name: Stephen H Schulte MD

Academic Title: Residency Director

Telephone: (585) 442-7470 Today's Date: 9/20/04

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

Seal Verified

DATE: 9/28/04

INITIALS: AF

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IN MEDICINE

SUPPLEMENT FORM

PRINT NAME: MOORE, NICOLA LOUISE DATE: 9/11/04

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

		YES	NO
1.	Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2.	Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
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.	Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5.	Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?		
6-A.	Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7.	Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards?		
8-A.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B.	Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

PRINT NAME: MOORE, NICOLA LOUISE

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to 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 related to professional competency or conduct 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 been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: Nicola Louise Moore **Date:** 9/11/04

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore **License No.:** 223184

PART A

1) Current Status: Active **Renewal Due Date:** 12/02/2005 **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.

RECEIVED NOV 14 2005 BOARD OF REGISTRATION IN MEDICINE

2a) MAILING ADDRESS

☐ *Check here to change this address.*

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___) _____

Phone

☐ *Check here to change this address*

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Business Address: 49 Harry Kemp Way

City/Town: Provincetown State: MA

Zip: 02657 Country: USA

Business Telephone: (508) 487 9395

Phone:

☒ *Check here to change this address*

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: (508) 487-3285

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Family Practice	☐	
	☐	
	☐	

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**	**Correct?**	**Delete?**
Family Medicine	ABMS	Family Practice	☐	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore **License No.:** 223184

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

a) Massachusetts:

b) Federal (DEA)

c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

NY CA

8b) States where you were previously licensed (Abbr.)

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

Principal Work Setting: Change to: CLINIC

Please enter the *approximate* number of work hours at your principal work setting: 40

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 ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Beth Israel Deaconess Medical Center	☐	Courtesy		Ø
	☐			
Clinic Outer Cape Health Services-Provincetown	☐	Active		40
Clinic Outer Cape Health Services-Wellfleet	☐	Active		Ø
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk

b) outpatient care 0 hrs/wk Change to: 40 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: FTCA Change to: ____

Policy dates: From 6/23/96 To __/__/____ no set expiration date
(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: Nicola L Moore **License No.:** 223184

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: Nicola L Moore **License No.:** 223184

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: Nicola Moore Date: 10,12,05

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

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore **License No.:** 223184

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.

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

☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐

☐ I have personally applied for an NPI.

☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)

☒ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 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 Q 0 0 0 0 0 X	Family Practice
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): U.K.

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.

Signature: Nicola Moore Date: 10/12/05

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

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

PART A

1) **Current Status:** Active **Renewal Due Date:** 12/02/2007 **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

☐ *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

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Board of Registration in Medicine

2c) BUSINESS ADDRESS

~~Outer Cape Health Services~~
~~49 Harry Kemp Way~~
~~Provincetown, MA 02657~~

~~Phone: (508)487-9395~~

☒ *Check here to change this address*

Business Address: St Luke's Mission Hospital

City/Town: Private Bag 5314 State: _____

Zip: Bulawayo Country: Zimbabwe

Business Telephone: (___) 263898349

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: ~~(508)487-3285~~

Correct your E-mail and Fax Number below:

_____

_____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Family Medicine	☐	
	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

(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:		NY CA
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?
Beth Israel Deaconess Medical Center			☒
Outer Cape Health Services, Inc.			☒
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: 0 hrs/wk

b) outpatient care 40 hrs/wk Change to: 0 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: Federal Tort Claims Act Change to: _____

Policy dates: From ___/___/____ To ___/___/____

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)*: practicing in Zimbabwe, where there is no insurance of any kind.

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: Nicola L Moore, M.D. **License No.:** 223184

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.)*

☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore, M.D. License No.: 223184

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: /Nicola Moore per Sally Moore, Power of Attorney Date: 12/26/2007

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.

$600.00 #2763 2/26/08

MA License Number: 223184
Date license revived: 2/26/08

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

RECEIVED FEB 26 2008 Board of Registration in Medicine

LAPSED LICENSE APPLICATION

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

Activity Status: ☒ Active ☐ Inactive*

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

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

Medical Degree: ☒ M.D. ☐ D.O. ☐ Ph.D. ☐ Other degree_____

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

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

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

Place of Birth: London England U.K.
City State/Province/Territory Country if not USA

Home Address: _____ _____
Number and Street

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

Business Address: _____ _____
Number and Street

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

Business Telephone: ___ ___ ____ Ext. _____ Home Telephone: ___ ___ ____

E-mail Address _____ Fax Number: _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

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

APPLICANT'S NAME: NICOLA LOUISE MOORE

Postgraduate Education:

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

			From	To
Facility: Highland Hospital University of Rochester	Position: Intern		6/21/99	6/28/00
Street: 1000 South Ave	City: Rochester	State: NY		
Facility: Highland Hospital University of Rochester	Position: Resident		6/29/00	9/22/02
Street: 1000 South Ave	City: Rochester	State: NY		
Facility: Highland Hospital University of Rochester	Position: Fellow		9/23/02	6/30/03
Street: 1000 South Ave	City: Rochester	State: NY		
Facility: University of Liverpool	Position: Diploma Student		2/7/05	5/3/05
Street: Pembroke Place	City: Liverpool	State: ~~Liverp~~ England		
Facility:	Position:		__/__/__	__/__/__
Street:	City:	State:		

Hospital Affiliations and Employment ☆

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

			From:	To:
Facility: Univ of Rochester	Position: Instructor		09/02	09/03
Street: 885 South Ave	City: Rochester	State: NY		
Facility: Strong Mem Hosp	Position: Assoc Attending		12/02	12/04
Street: 3013 Elmwood Ave	City: Rochester	State: NY		
Facility: Highland Hospital	Position: Assoc Attending		1/03	12/04
Street: 1000 South Ave	City: Rochester	State: NY		
Facility: Univ of Rochester	Position: Clin Instructor		10/03	9/04
Street: 885 South Ave	City: Rochester	State: NY		
Facility: Westside Health Services	Position: ~~Phy~~ Physician		09/02	06/03
Street: 175 Lyell Ave	City: Rochester	State: NY		
Facility: Mpilo Central Hospital	Position: Expatriate Orienka		11/03	7/04
Street: Mpilo Campus	City: Bulawayo	State: ~~Zim~~ Zimbabwe		

☆ See attached for additional information.

APPLICANT'S NAME: Nicola Louise Moore

			From:	To:
Facility:	Medicins Sans Frontieres Hosp	Position: Doctor	10/04	2/05
Street:	Ler	City: Ler	State: South Sudan	
Facility:	Outer Cape Health Services	Position: FP Doctor	8/05	12/05
Street:	47 Harry Kemp Way	City: Provincetown	State: MA	
Facility:	St. Francis Hospital	Position: Doctor	1/06	5/06
Street:	Lusaka Road	City: Katete	State: Zambia	
Facility:	Outer Cape Health Services	Position: FP Doctor	6/06	9/06
Street:	47 Harry Kemp Way	City: Provincetown	State: MA	
Facility:	St. Luke's Mission Hospital	Position: Doctor	10/06	present
Street:	Victoria Falls Road	Citiy: Lupane	State: Zimbabwe	

Medical Malpractice Information:

My medical malpractice insurance coverage is by: ☐ Insurance carrier ☐ Letter of Credit

Print name of insurer: _____

Policy dates: From: _____ To: _____

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

☒ I am not involved in direct patient care ☐ Otherwise exempt

Explain exemption I am not involved in direct patient care in MASSACHUSETTS. I work in Zimbabwe at the moment.

Continuing Medical Education Credits

Read instructions for continuing medical education requirements before completing.

Activity status: ☒ Active ☐ Inactive ☐ Exemption _____

Category 1 credits 105 Risk management Category 1 10
Category 2 credits _____ Risk Management Category 2 _____

Continuing medical education credit requirements must be completed before the Lapsed License can be revived if you are applying for active license status. (See Lapsed License Instructions).

1. List other states (abbreviations) where you are currently or have ever been licensed: NY CA
2. Are you certified by the American Board of Medical Specialties (ABMS)? ☒ Yes ☐ No
3. List only ABMS certification(s): American Board of Family Medicine
4. Reason for reviving Lapsed License in Massachusetts: The lapse occured because I was overseas and my mail was not sent to me as instructed. I would like to work in direct patient care again in Massachusetts in the near future.
5. Please attach your current curriculum vitae

Continued on page 4

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

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

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under the penalties of perjury, I declare that I have examined this lapsed application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct and complete. As an applicant for revival of a lapsed license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: Nicole Moore Date: 2/25/08

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

Continued on Page 5

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers such as those assigned by health plans, government programs and health care purchasers for the purposes of conducting these business transactions. Under the HIPPA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number you must notify the Board (see instructions for Option 2).

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

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

☒ My current NPI is: 1134166184

☐ I have personally applied for an NPI.

☐ I have applied for an NPI using a third party (enter name) _____ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207Q00000X	Family Medicine
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): U.K.

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

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

Signature: Victoria Louise Moore Date: 2/25/08

Nicola Louise Moore
email:

USA:

Zimbabwe St Luke's Mission Hospital, P. Bag R5314, Bulawayo, Zimbabwe
Zimbabwe Hospital: 263 (0) 898 362/349

EDUCATION

UNIVERSITY OF LIVERPOOL	Diploma in Tropical Medicine and Hygiene	2005
UNIVERSITY OF ROCHESTER	Fellowship in Family Planning	2003
UNIVERSITY OF ROCHESTER	Residency in Family Medicine	2002
ALBERT EINSTEIN COLLEGE OF MEDICINE	Doctor of Medicine	1999
YALE UNIVERSITY	Master of Public Health	1982
YALE UNIVERSITY	Bachelor of Arts	1976

ACADEMIC AND HOSPITAL APPOINTMENTS:

8/05-9/06 STAFF (Courtesy)
Department of Medicine, Beth Israel Deaconess Medical Center, Boston, Massachusetts

10/03-9/04 CLINICAL INSTRUCTOR
Department of Family Medicine, School of Medicine and Dentistry, University of Rochester, Rochester, New York

1/03-12/04 ASSOCIATE ATTENDING WITH ADMITTING PRVILEGES
Highland Hospital, Rochester, New York

12/02-12/04 ASSOCIATE ATTENDING WITH ADMITTING PRIVILEGES
Department of Pediatrics, Strong Memorial Hospital, Rochester, New York

9/02-9/03 INSTRUCTOR IN FAMILY MEDICINE
School of Medicine and Dentistry, University of Rochester, Rochester, New York

11/00-6/02 ASSOCIATE IN FAMILY MEDICINE
School of Medicine and Dentistry, University of Rochester, Rochester, New York

WORK EXPERIENCE

10/06-*present* St. Luke's Mission Hospital, Lupane, Zimbabwe
DOCTOR.
Provides outpatient, inpatient and obstetrical/gynecological care in rural hospital. Manages and provides all physician services in hospital-based HIV clinic, including caring for 700 adult and pediatric patients receiving anti-retroviral medication and providing related inpatient services, and caring for approximately 2000 other HIV-positive patients.

1/06-5/06 St. Francis Hospital, Katete, Zambia
DOCTOR.
Provided outpatient, inpatient, HIV/AIDS and obstetrical/gynecological services to remote rural population in large limited-resource referral hospital.

- General outpatient pediatric, adult and gynecological care; care of HIV-positive patients (pregnant patients, adults, infants and children), including management of ARVs
- Surgical obstetrics and gynecology: cesarean section, instrumental delivery, bilateral tubal ligation, evacuation of retained products of conception, ectopic pregnancy management and adnexal cystectomy.

8/05-12/05 and 6/06-9/06 **Outer Cape Health Services, Provincetown and Orleans, Massachusetts**
FAMILY PRACTICE PHYSICIAN.
Provided primary care services at a rural community health center.

10/04-02/05 **Medicins Sans Frontieres – Holland, Ler, Western Upper Nile, South Sudan**
DOCTOR.
Provided outpatient, and inpatient services in remote rural area with extremely limited resources: tropical and parasitic diseases, tuberculosis, sexually transmitted diseases, malnutrition, wound management, obstetrics, abortion management.

11/03-7/04 **Ministry of Health and Child Welfare, Bulawayo, Zimbabwe**
GOVERNMENT MEDICAL OFFICER – ORIENTEE.
Provided clinical services in large referral hospital while receiving orientation to local protocols for medicine, pediatrics, obstetrics, gynecology and surgery. Focus on reproductive health issues, including pregnancy completion and management of septic abortion.

9/02-6/03 **Westside Health Services – Brown Square Health Center, Rochester, New York**
FAMILY PRACTICE PHYSICIAN.
Full spectrum family practice, including obstetrics, in inner-city community health center and community hospital...

9/02-6/03 **Department of Family Medicine, University of Rochester, Rochester, New York**
FAMILY PLANNING CLINICAL AND RESEARCH FELLOW.
Reproductive health services, including family planning, abortion/pregnancy completion, sexually transmitted disease management in multiple public and private outpatient facilities.

7/99-9/02 **Highland Hospital and Brown Square Health Center, Rochester, New York**
FAMILY MEDICINE RESIDENT.
- Primary care - inner-city community health center, 50% Hispanic; 90% Medicaid.
- Obstetrics/Gynecology - advanced training, including 6 months of inpatient obstetrics, large continuity OB practice.
- Inpatient Services - community hospital, including clinical care, teaching and supervision
- Emergency care - pediatric, surgical and medical ED services

8/92-6/94 **Albert Einstein College of Medicine/Montefiore Medical Center, Bronx, New York**
PROJECT DIRECTOR, TUBERCULOSIS INITIATIVE.
Coordinated multiple tuberculosis-related activities for facilities associated with an urban medical center and its medical school affiliate (including hospitals, community health centers, methadone maintenance treatment facilities and a prison health service).
- Established and managed directly observed therapy program (20,000 visits/year) to serve pediatric and adult TB patients (80% HIV-infected).
- Established, with prison staff and health department and provider representatives, new systems for coordinating post-release care of inmates with tuberculosis.

1/87-7/92 **Montefiore Medical Center, Moses Division, Bronx, New York**
DIRECTOR OF OPERATIONAL SERVICES.
Hired to improve support and ancillary services of 750 bed hospital.
- Established two support service departments: supervised 25 employees; responsible for $8 million supply and $1 million capital budgets.
- Redesigned major non-clinical services for 35 inpatient units: scheduling and coordination of diagnostic procedures; transport of patients; acquisition and distribution of supplies.
- Coordinated operations aspects of all inpatient facilities renovations.

6/81-12/86 **Arthur D. Little, Inc., Health Care Management, Cambridge, Massachusetts**
CONSULTANT.
Managed consulting projects for government, private and public health care clients. Provided planning, technical assistance, operations review for clinics, hospitals, HMOs and vendors of health care products.

10/79- 6/81 **Yale University School of Medicine, Department of Epidemiology and Public Health, New Haven, Connecticut**
ASSISTANT IN RESEARCH.
Evaluated changes in quality of care of renal stone patients in Connecticut community hospitals: abstracting and coding medical records data, data analysis and report preparation.

10/78- 5/79 **University of Connecticut Health Center, Department of Nuclear Medicine, Farmington, Connecticut**
RESEARH ASSISTANT.
Performed animal experimentation with radioactive tracers for diagnostic scanning.

5/77- 2/78 **Yale Psychiatric Institute, New Haven, Connecticut**
PSYCHIATRIC AIDE.
Coordinated treatment plans and daily activities for 20 schizophrenic adolescents in milieu therapy setting.

VOLUNTEER EXPERIENCE:

3/03- 5/03 **Mpilo Central Hospital, Bulawayo, Zimbabwe**
Provided obstetrical and gynecological care in large referral hospital. Provided ante-natal, delivery and post-natal care and performed completion of incomplete abortions. Trained attending physicians and housemen in related procedures. Sponsored by Rotary International.

2/01- 3/01 **Mondaña Clinic, Napo Province, Ecuador**
Provided primary care and participated in child survival outreach project in Amazon jungle.

6/00- 11/00 **Finger Lakes Migrant Health, Ontario County, New York**
Provided screening, vaccinations and primary care services to laborers and their families at farm worker camps.

9/95- 6/96 **New York Harm Reduction Educators, Inc. and Citiwide Needle Exchange, Bronx, New York**
Participated in street-based needle exchange programs for IVDUs. Provided clean needles, safe-sex and safe-injection education and medical and social service referrals. Organized on-going medical student participation in exchange and in influenza and pneumococcal vaccination programs; recruited and trained students.

HONORS AND AWARDS

The Highland Hospital Family Medicine Women's Health Care Award for Outstanding Accomplishment in the Field of Women's Health, 2002.

LICENSING AND CERTIFICATION

Board Certified, American Board of Family Practice
Medical Registration, Zambia
Medical Registration, Zimbabwe
California License number 89646
Massachusetts License number 223184
New York License number 219226
ACLS
BLS

LANGUAGES

Spanish, medical and basic
Ndebele, medical

REFERENCES

Available on request.

SUPPLEMENT FORM FOR LAPSED APPLICATION

PRINT NAME: NICOLA LOUISE MOORE DATE: 2/25/08

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
1-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
2. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
3-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
3-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		
4-A. Have you ever voluntarily relinquished any medical staff membership?		
4-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
4-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
4-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
5. Have you ever been charged with any criminal offense, other than a minor traffic offense?		
6. Has your privilege to 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?		

Signed: Nicola Louise Moore Date: 2/25/08

		YES	NO
7.	Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
8.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
9.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
10-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
10-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: Victoria Louise Moore Date: 2/25/08

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

PART A

1) Current Status: Active **Renewal Due Date:** 12/02/2008 **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.

2a) MAILING ADDRESS

DEC 15 2008
Board of Registration in Medicine

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

Phone

☐ *Check here to change this address*

3) E-mail Address:

4) Fax Number: (508)487-3285

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

No fax number

5) Specialties (*See Renewal Instructions, page 4.*)	**Delete?**	**List Additional Specialties:**
Family Medicine	☐	
	☐	
	☐	

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?**
Family Medicine	ABMS	Family Medicine	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

NY CA Iowa Nebraska ___ ___

9) States where you were previously licensed

___ ___ ___ ___ ___ ___ ___

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?
Beth Israel Deaconess Medical Center			☒
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk

b) outpatient care 40 hrs/wk Change to: 0 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: Federal Tort Claims Act Change to: none

Policy dates: From ___/___/____ To ___/___/____

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: Nicola L Moore, M.D. **License No.:** 223184

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: Nicola L Moore, M.D. **License No.: 223184**

12/16/08 S1 207

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: Nicola L Moore Date: 11/21/08

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

Mass.Gov • online services • agencies •

Massachusetts Board of Registration in Medicine Physician Profile

Nicola L. Moore, M.D.

I. Physician Information

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

License Status:	Active
License Issue Date:	2/16/2005
Accepting New Patients:	~~Yes~~ N/A
Accepts Medicaid:	~~Yes~~ N/A
Primary Work Setting:	Clinic
Business Address:	1 Richdale Avenue Apt. 15 Cambridge, MA 02140
Phone:	(617) 868-9887
Translation Services Available:	~~Portuguese~~ ~~Spanish~~ N/A
Insurance Plans Accepted:	~~Numerous Plans Accepted~~ N/A
Hospital Affiliations:	~~Beth Israel Deaconess Medical Center~~ none

II. Education & Training

Medical School:	Albert Einstein College of Medicine Yeshiva Univ
Graduation Date:	1999
Post Graduate Training:	Univ. of Rochester - Intern - Family Practice (6/21/1999-6/28/2000) Univ. of Rochester - Resident - Family Practice (6/29/2000-9/22/2002) University of Rochester - Fellow - Family Practice (9/23/2002-6/30/2003) Univ of Liverpool- DT Mand H (2/7/2005-5/3/2005)

III. Specialty

Area of Specialty:	Family Medicine

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Medicine	

V. Honors and Awards

The Highland Hospital Family Medicine Women's Healthcare Award for Outstanding Accomplishment in the Field of Women's Health, 2002.

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. Moore 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. Moore 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. Moore 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. Moore 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 781-876-8230
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
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Phone 781-876-8200
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

Current Status: Active **License Expiration Date:** 12/30/20

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
California
Iowa
Mississippi
Nebraska
New York

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

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
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
National Fire & Marine Insurance	01/01/2010	01/01/2011	Claims made with tail coverage
National Fire & Marine Insurance	07/01/2010	07/01/2011	Claims made with tail coverage

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?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

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)

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?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Nicola L Moore, M.D. **License No.:** 223184

Compliance with Legal Responsibilities

Online profile:

☒ 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.

☒ **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.**

☒ **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.**