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JUN 23 2008
Board of Registration in Medicine

REDACTED COPY

Application #: 236470
Date of Issue: ___/___/___

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. The application fee is non-refundable.

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

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

Spurrell, Timothy Patrick
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: Lowell, MA
City State/Province/Territory Country if not USA

Home Address: _____
Number and Street

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

Business Address: 215 Toll Gate Road, #306
Number and Street

Warwick, RI 02886
City State/Province/Territory Zip (or postal) Code

Business Telephone: (401) 739-2000, ext. _____ Home Telephone: _____

E-mail Address: _____

Preferred Mailing Address: ☐ Business Address ☑ Home Address

Are you applying for licensure through FCVS? (See instructions page 11) ☐ Yes ☑ No

6/14/08

08/23/08 SI 4

Pre-medical School

Facility: University of Massachusetts, Lowell Degree: N/A From 09/ /81 To 05/ /83
Street: 883 Broadway Street, Room 104 City: Lowell State: MA

Facility: Radford University Degree: BS 09/ /83 12/ /85
Street: 115 Martin Hall, PO Box 6904 City: Radford State: VA

Medical School

Facility: University of Connecticut Degree: MD From 08/21/92 To 05/23/96
Street: 263 Farmington Avenue, MC1827 City: Farmington State: CT

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

Date of medical school graduation: 05 / 23 / 1996
Month Day Year

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.

From To

Facility: Women and Infant's Hospital of Rhode Island Position: OB/GYN Residency 06/24/96 06/23/00
Street: 101 Dudley Street City: Providence State: RI

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

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

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

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

TSpm 6/14/08

RECEIVED
APR 22 2008
Board of Registration in Medicine

Ck# 0117513 $600.00

Application #: 236470 $600.00
Date of Issue: ___/___/___

08/25/08 S1

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. The application fee is non-refundable.

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

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

Spurrell, Timothy Patrick
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: Lowell, MA
City State/Province/Territory Country if not USA

Home Address: _____ _____
Number and Street

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

Business Address: 215 Toll Gate Road, #306
Number and Street

Warcick, RI 02886
City State/Province/Territory Zip (or postal) Code

Business Telephone: (401) 739-2000, ext. _____ Home Telephone:

E-mail Address: _____ _____

Preferred Mailing Address: ☐ Business Address ☐ Home Address

Are you applying for licensure through FCVS? (See instructions page 11) ☐ Yes ☑ No

PRINT NAME: Timothy Spurrell, MD

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: Women and Infant's Hospital of Rhode Island	Position: Staff Privileges	06/ /00	Present
Street: 101 Dudley Street	City: Providence	State: RI	
Facility: Women's Care	Position: Phyisican	08/ /00	08/ /01
Street: 390 Toll Gate Road	City: Warwick	State: RI	
Facility: Rhode Island Hospital	Position: Staff Privileges	08/ /00	Present
Street: 593 Eddy Street	City: Providence	State: RI	
Facility: Caring for Women	Position: Physician/Partner	08/ /01	Present
Street: 215 Toll Gate Road, #306	City: Warwick	State: RI	

1. List other states (abbreviations) where you are currently or have ever been licensed: RI
2. Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
3. List Board Certification(s): American Board of Obstetrics & Gynecology Certification date: 10 / /03

   Certification date: / /
4. List your practice specialt(ies) OB/GYN
5. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
6. Reason for requesting a Massachusetts medical license:

8. Name of Facility:
9. Address: City:
10. Anticipated starting date in Massachusetts: / /

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.

Signature of Applicant

6 / 14 / 09.
Month Day Year

(Continued on page 4)

08/26/08 S1 8

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.

Facility / Street	Position / City	From / State	To
Facility: Women and Infant's Hospital of Rhode Island	Position: Staff Privileges	06/ /00	Present
Street: 101 Dudley Street	City: Providence	State: RI	
Facility: Women's Care	Position: Phyisican	08/ /00	08/ /01
Street: 390 Toll Gate Road	City: Warcick	State: RI	
Facility: Rhode Island Hospital	Position: Staff Privileges	08/ /00	Present/
Street: 593 Eddy Street	City: Providence	State: RI	
Facility: Caring for Women	Position: Physician/Partner	08/ /01	Present
Street: 215 Toll Gate Road, #306	City: Warcick	State: RI	

1. List other states (abbreviations) where you are currently or have ever been licensed: RI ___ ___
2. Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
3. List Board Certification(s): American Board of Obstetrics & Gynecology Certification date: 10 / /03

   ______ Certification date: / /
4. List your practice specialt(ies) OB/GYN
5. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: TO EXPAND MY PRACTICE

8. Name of Facility: ______
9. Address: ______ City: ______
10. Anticipated starting date in Massachusetts: 07/ /08

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.

Signature of Applicant [signature]

02/10/2008
Month Day Year

(Continued on page 4)

PRINT NAME: Timothy Spurrell, MD

08/25/08 S1 7

Pre-medical School

			From	To
Facility: University of Massachusetts, Lowell	Degree: N/A		09/ /81	05/ /83
Street: 883 Broadway Street, Room 104	City: Lowell	State: MA		
Facility: Radford University	Degree: BS		09/ /83	12/ /85
Street: 115 Martin Hall, PO Box 6904	City: Radford	State: VA		

Medical School

			From	To
Facility: University of Connecticut	Degree: MD		08/ /92	05/ /96
Street: 263 Farmington Avenue, MC1827	City: Farmington	State: CT		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 05 / 23 / 96
(Month / Day / Year)

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.

			From	To
Facility: Women and Infant's Hospital of Rhode Island	Position: OB/GYN Residency		06/ /96	06/ /00
Street: 101 Dudley Street	City: Providence	State: RI		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

08/26/08 S1 11

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 full license application to be complete, 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. You must notify the Board once you have received your NPI Number. 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). You must notify the Board once you have received your NPI Number.

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: 1 1 2 0 0 0 8 7 4 1

☐ 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 page 12 of Full License Application Instructions). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

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

NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note**: This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (if US): MA Country of Birth (if outside the US): _____

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.

_____ 2/10/09

Signature of Applicant Date

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

Massachusetts Application for Licensure
Timothy Spurrell, MD
Addendum to Hospital Affiliations & Employment:

Facility Name & Address	Position	Dates of Affiliation
Kent County Memorial Hospital 455 Toll Gate Road Warcick, RI 02886	Staff Privileges	08/2001 - Present

1987-1989 Mental Health Worker, McLean Hospital, Belmont, MA
Counseled hospitalized patients as part of a multidisciplinary team.

RESEARCH EXPERIENCE:

2001 Frishman G.N., Spurrell T.P., Heber W.W. *Folic Acid preconception knowledge; use by infertile women.* Journal of Reproductive Medicine. 2001 46 (12): 1025-30.

1993-1994 Research Project University of Connecticut School of Medicine, Farmington, CT. *Is social support a predictor for psychotropic medication use in the nursing home?* Awarded $10,000 grant from the American Federation of Aging Research to conduct study.

1989-199 Research Assistant, Harvard Medical School, The Cambridge Hospital Cambridge, MA.
Adapted Luborsky's Relationship Anecdote Paradigm Model to Psychotherapy transcripts to assess patterns of self defeating behavior in persons at high risk for HIV/AIDS.

1988-1989 Research Assistant, Harvard Graduate School of Education, MA. Researched, reviewed and critiqued the philosophical, empirical and clinical papers regarding the development and understanding of emotional ambivalence.

TEACHING EXPERIENCE:

2000- present Voluntary Teaching Faculty, Women and Infants Hospital of Rhode Island

1992-1996 Member, Clinical Medicine Committee, University of Connecticut School of Medicine, Farmington, CT.
Developed new curriculum emphasizing primary prevention and wellness.
Authored syllabi and led seminars for first year medical students.

1992-1996 Seminar Instructor, University of Connecticut School of Medicine, Farmington, CT. Led seminars for health center staff and employees in The areas of sexual harassment and diversity training.

HONORS, AWARDS AND ACTIVITIES:

2001 Voluntary Faculty Teaching Award, Brown University
2001 Dean's Teaching Excellence Award, Brown University
1999-present Member, OB/GYN Resident Task Force
1996-1998 Medical Student Teaching Award
1996 Merck Scholar, University of Connecticut School of Medicine
1992-1996 Peer Counselor, University of Connecticut School of Medicine

OTHER EMPLOYMENT:

CURRICULUM VITAE

TIMOTHY P. SPURRELL, M.D., M.Ed.

PERSONAL DATA:

Residence:

Business: Caring For Women
166 Toll Gate Road
Warwick, RI 02886

E-Mail:

Birth Date:

EDUCATION:

M.D. University of Connecticut School of Medicine, 1996 Farmington, CT

M. Ed. Harvard Graduate School of Education, 1990, Cambridge, MA
Counseling Psychology

B.S. Radford University, Radford, VA
Accounting

CLINICAL EXPERIENCE:

8/01-present Caring For Women 166 Toll Gate Road Warwick, RI 02886
2000-2001 Women's Care 390 Toll Gate Road Warwick, RI 02886
1996-2000 Resident, Women & Infants Hospital, Department of OB/GYN, Providence, RI
1990-1992 Staff Psychotherapist, Milford Mental Health Clinic, Milford, CT
Engaged in weekly individual and group therapy with adults suffering from both acute and chronic psychiatric conditions.
1988-1990 Mental Health Worker, The Cambridge Hospital, Psychiatric Emergency Department, Cambridge, MA
Served as the psychiatric staff to the emergency room to provide evaluation and disposition for patients presenting with acute psychiatric issues.
1987-1989 Case Manager/Counselor, North Suffolk Mental Health Association Chelsea, MA
Supervised mentally retarded/emotionally disturbed adults in a residential treatment facility. Developed and implemented individual service plans.

Full License Application

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: _____ Date of Birth _____

Print or Type Name: Spurrell, Timothy Social Security No. _____
(Last name) (First Name) (Middle Initial)

Other Name(s) _____

Name of Medical School: (Please type or print name(s)) University of Connecticut School of Medicine

Address: 263 Farmington Avenue, MC1827 City: Farmington State or Province: CT

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: Radford University, VA

Undergraduate School Address: _____

(Continued on page 2)

1986-1987 Stockbroker, EF Hutton, Cambridge, MA.

PROFESSIONAL MEMBERSHIPS:

2000-present American College of Obstetrics and Gynecology Fellow

REFERENCES:

Donald R. Coustan, M.D. Obstetrics and Gynecologist in Chief
Professor and Chairman

Gary Frishman, M.D. Associate Professor of Obstetrics and Gynecology
Reproductive Endocrinology

Lori Boardman, M.D. Assistant Professor of Obstetrics and Gynecology
General Obstetrics and Gynecology

LIMITED LICENSE APPLICANT

Faxed Copy - Ready for 8/20/08 BD

COMMONWEALTH OF MASSACHUS **TRATION IN MEDICINE**

560 Harrison Avenue, Suite #G-4, Boston, Mass -9810 www.massmedboard.org

MEDICAL EDU ON

APPLICANT INSTRUCTIONS: Please complete the waiver for releas ... information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

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

Applicant's Signature: Soremekun O. Date of Birth

Print or Type Name: SOREMEKUN (Last name) OLANREWAJU (First Name) A (Middle Initial) Social Security No:

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

Name of Medical School: COLUMBIA UNIVERSITY, COLLEGE OF PHYSICIANS & SURGEONS

Address: _____ City: NEW YORK 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) to the applicant. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Continued on page 2

Enrollment and Participation: Our records indicate that

Full License Application

Enrollment and Participation: Our records indicate that

Spurrell, Timothy

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/21/1992	05/23/1996	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

The applicant attended 164 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☑ was awarded a degree in Doctor of Medicine on (month/day/year) 05/23/1996

☐ 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: Janice Gilkes

Print Name: Janice Gilkes

Title: Registrar

Date: 06/12/08 Telephone: (860) 679-2990

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

Seal Verified

DATE: 6/17

INITIALS: JG

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: _____ Date of Birth _____

Print or Type Name: Spurrell, Timothy _____ Social Security No: _____
(Last name) (First Name) (Middle Initial)

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

Name of Medical School: University of Connecticut

Address: 263 Farmington Avenue, MC1827 City: Farmington State or Province: CT

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: _____

Undergraduate School Address: _____

(Continued on page 2)

LIMITED LICENSE APPLICANT – FORM A

ollment and Participation: Our records indicate that

Soremekun	Olanrewaju	A.
(Last name)	(First name)	(Middle initial)

e or print the applicant's name):

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

ENDANCE DATES:

FROM	TO	FROM	TO
8/30/99	6/2/00	7/1/03	5/19/04
8/28/00	6/25/01	/ /	/ /
6/25/01	6/21/02	/ /	/ /

The applicant attended 160 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) 5/19/04

☐ will be awarded on ____/____/____ **(Form B must also be completed and returned with this Form A)**

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

	YES	NO
id the applicant take any leaves of absence or breaks from his/her medical education? (Explain "personal leaves".)		
/as the applicant ever placed on probation?		
/as the applicant ever disciplined or under investigation?		
/ere any negative reports ever filed by instructors regarding the applicant?		

MENTS: Dual Degree Student MD/MBA (See Transcript)

AFFIX INSTITUTIONAL SEAL HERE

e institution does not have a seal, this form must be rized)

ERNATIONAL MEDICAL SCHOOLS MUST ATTACH A Y OF THE MEDICAL SCHOOL DIPLOMA AND A NSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Carmen E. Sierra

Print Name: Carmen E. Sierra

Title: Assistant Director, SAS

Date: 8/11/2008 Telephone: (212) 342-4790

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

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: [signature] Date: 2/18/08

Print or Type Name: Timothy Spurrell, MD

Name of Institution: Women and Infant's Hospital of Rhode Island

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: Women & Infants Hospital / Brown University

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

Enrollment and Participation: Our records indicate that Timothy Spurrell (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
Residency	1	OB/GYN	6/24/1996	6/23 1997	yes	ACGME
Residency	2	OB/GYN	6/24/1997	6/23 1998	yes	ACGME
Residency	3	OB/GYN	6/24/1998	6/23 1999	yes	ACGME
Residency	4	OB/GYN	6/24/1999	6/23 2000	yes	ACGME

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Spurrell, Timothy

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/21/92	6/15/93	7/1/95	5/23/96
	8/23/93	6/14/94	/ /	/ /
	7/1/94	6/30/95	/ /	/ /

The applicant attended 164 total weeks or 44 total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☑ was awarded a degree in Doctor of Medicine on (month/day/year) 5/23/96

☐ 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: Linda Greno

Print Name: Linda Greno

Title: Assistant Registrar

Date: 3/26/08 Telephone: (860) 679-3125

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

Seal Verified

DATE: 6/10

INITIALS: [illegible]

SUPPLEMENT FORM

PRINT NAME: Timothy Spurrell, MD DATE: 12 / 06 / 07

08/26/08 SI 46

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. 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, any other certification body 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 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)?		

Applicant's Signature: _____ Date: 2/10/08

POSTGRADUATE VERIFICATION FORM PAGE - 2

APPLICANT'S NAME: Timothy Spurrell, MD

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.

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Donald R. Coustan

Print Name: Donald R. Coustan, M.D.

Academic Title: OB/GYN-in-Chief

Telephone: (401) 274-1100 x 575 Today's Date: 2/19/2008

Seal Verified DATE: 2/20 INITIALS: [illegible]

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

		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: _____ **Date:** 2/10/08

		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: _____ **Date:** 6,14,08

Massachusetts Physician Renewal Application

Physician Name: Timothy P Spurrell, M.D. **License No.: 236470**

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(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		RI
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?
PLANNED PARENTHOOD	BOSTON	MA	☐
PLANNED PARENTHOOD	WORCESTER	MA	☐
			☐
			☐
			☐

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: 15 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: Change to: _____

Policy dates: From 1/1/09 To 1/1/10

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: Timothy P Spurrell, M.D. **License No.: 236470**

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PART A

1) Current Status: Active **Renewal Due Date:** 01/19/2009 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

1363 Narragansett Boulevard
Cranston, RI 02905

RECEIVED
JAN 22 2009
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Caring for Women
215 Toll Gate Road, #306
Warwick, RI 02886

Phone: (401)739-2000

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401 732 7842

Correct your E-mail and Fax Number below:

_____

_____

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy P Spurrell, M.D. **License No.: 236470**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 01/08/2009

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURERS AFFORDING COVERAGE	NAIC #
INSURER A: N/A	N/A
INSURER B: National Union Fire Insurance Company	19445
INSURER C:	
INSURER D:	
INSURER E:	

INSURED
PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS
AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.
1055 COMMONWEALTH AVENUE
BOSTON, MA 02215-1001

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES(Ea occurence)	$
		CLAIMS MADE ☐ OCCUR				MED EXP (Any one person)	$
						PERSONAL & ADV INJURY	$
						GENERAL AGGREGATE	$
		GENERAL AGGREGATE LIMIT APPLIES PER: POLICY ☐ PRO-JECT ☐ LOC				PRODUCTS - COMP/OP AGG	$
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		ANY AUTO				BODILY INJURY (Per person)	$
		ALL OWNED AUTOS					
		SCHEDULED AUTOS				BODILY INJURY (Per accident)	$
		HIRED AUTOS					
		NON-OWNED AUTOS				PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		OCCUR ☐ CLAIMS MADE ☐				AGGREGATE	$
		DEDUCTIBLE					$
		RETENTION $					$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS ☐ OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
B		OTHER MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE PROGRAM RETRO: 11/01/76	6793286	01/01/09	01/01/10	PER CLAIM AGGREGATE	1,000,000 3,000,000

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS
DR. TIMOTHY SPURRELL IS AN INSURED UNDER THE ABOVE REFERENCED POLICY.

CERTIFICATE HOLDER NYC-003105257-01

TIMOTHY SPURRELL
C/O PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS
1055 COMMONWEALTH AVE.
BOSTON, MA 02215

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.
Chris Kakel

Chris Kakel

Massachusetts Physician Renewal Application

Physician Name: Timothy P Spurrell, M.D. **License No.: 236470**

01/23/09 S1

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: Tim SPURRELL Date: 1/15/09

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Timothy P Spurrell, M.D. **License No.:** 236470

Current Status: Active **License Expiration Date:** 2/16/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

Caring for Women
215 Toll Gate Road, #306
Warwick
Rhode Island - 02886
United States of America
(401) 739-2000

3) **Email Address:**

4) **Fax Number:** (401) 732-7842

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts **Federal (DEA)** **Federal (DEA) XS**

8) **Other states where you are now licensed to practice**
Connecticut
Rhode Island

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

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

WorkSite **Location**

Physician Name: Timothy P Spurrell, M.D. **License No.:** 236470

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: Timothy P Spurrell, M.D. **License No.:** 236470

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 19 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	04/22/2010	04/22/2011	Occurrence Policy
Marsh USA, Inc	01/01/2011	01/01/2012	Occurrence Policy

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Timothy P Spurrell, M.D. **License No.:** 236470

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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