

## Commonwealth of Massachusetts Board of Registration in Medicine

10 West Street Boston, Massachusetts 02111

> (617)727-3088 Fax: (617) 451-9668

REDACTED COPY

April 24, 1997

Boris I. Orkin, M.D.

Complaint No. 97-053 Re:

Dear Dr. Orkin:

The Complaint Committee of the Board has considered the above referenced complaint and has determined that no further action is warranted. The complaint has been dismissed. Board staff, however, wished to offer you advice in regard to the patient's perception of insensitivity on your part. While a patient's perception in the midst of a traumatic situation might be inaccurate, any effort a physician might make to be sensitive to the patient's experience, such as covering specimens, will likely go a long way in making the experience easier to bear.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please call me at (617) 727-1788, Ext. 375, or write to me at the above address.

Sincerely.

Deirdre K. Manning

Consumer Protection Officer

#### BORIS ORKIN, M.D.

Obstatrice and Gynecology 1180 Beacon Street, Sillie 58 Brookline, Massachusetts 02146

Telephone: (617) 277-0090

March 8, 1997

Board of Registration in Medicine Consumer Protection Coordinator

Docket #: 97-053

in response to

complaint I'd like to provide following information:

was a patient at Crittenton Haisting House for pregnancy termination. She was referred by MGH where she was a patient for some time. Her past medical history is significant for veatibulite-disease that can cause significant pain in the vulva. underwent numerous vulvovaginal augeries to alleviate her pains and subsequently was taking Zoloit to relief her symptoms. She also has a history of pelvic and vaginal infections, including herpes genitalis. developed hepatitis accordery to anesthesis.

Critication Heliating House is facility that provides different services including pregnancy termination. Upon annivel patients stay on the first floor where they complete different forms and undergo extensive counsaling. This process takes some time until all the patient's quantions and concerns are resolved. After this process is completed the patient is taken to the third floor by a medical sestimant. The medical sestimant takings in the chart, helps the patient to change into appropriate clothes and takes her to the waiting room. Patients are taken for procedure, in the order that they arrived, on the third floor. Until this time the physician has no contact with the patient. In the procedure room an internal examt is performed with fubricated gloves in order to make it more comfortable and to alleviate decomfort from speculum treation. (Growing-history, all was done very carefully along with personvioral assertable. For which she received 20 pc of 1% apposition. Her convical canal was distailed after that. Suction was done, it is routine procedure to withdraw and relinest suction in order to secure that all these is removed. A sharp curete was not used dusing file, procedure. There were no complications of procedure as well as no that recorded that the pessed out or vormited, although local injections of apposition than tensive the room after being assured that patient the doing well. The medical assistant takes care of the patient after that. Sometimes, especially when patient has early pregnancy(as in case) it is essential to examine the tissue to assert

There is a betteroom on the third floor which has three separate cabins with looks inside of each door. One of the rooms has a sign for use by medical personnel, including doctors. There is also a scrub room which is located separate from the recovery and rest rooms. The scrub room is so small that it can accommodate only one person and that person can change clothes only when the door is closed. Medical personnel change their clothes before and latter each session.

correlationess of the procedure, instruments and tiesues are covered before taking them out of the room.

I feel sympathetic to h" concerns and hope that this explanation will satisfy all parties involved, but if it will be needed, we can arrange a meeting in the Critisation Haisting House-territory between the Board investigator and myself in order to clarify any issue.

BOLT, M.D

Respectfully.

Borts Orkin, M.D.



# Commonwealth of Massachusetts Board of Registration in Medicine

10 West Street n. Messachusetts 02111

a Apayor which appears the particle of Community Albeits and Business Regulation

LEXANDEN F. FLEMMO, J.D.

WILLS, J.D.	COMPL	LINT FOR	K.
Please type or print clearly, and	provide all of the inform	ation require	ted.
1 Mrs. Your First Name 8 Mr	Last Name	Patie	nt Name (if different)
Mr. Street Address		Maili	ng Address (if different)
City	State	Zip C	code
Husiness/Davtime Phone		Home	Phor-
Chirepractors, Dentists, ! the Division of Registration	verses, Optometrs at (617)727-3976	a, regnat , or 100 C	st (For complaints against ists or Psychologists, please contact ambridge St., Boston, MA 62262.) scian or scapanotarist. Phone verify spalling
Full Name (First & Last) of Ph	ysician or Acupuncturis	(one mante	per form) Photocopies are acceptable.
BURIS ORKIN	<u> </u>		
Address I. En Per City Boston	thshine Ro	l	
City	State	Zip C	Code
Buston	M.A	८०	.130
Susiness Phone	7.782	760	
lame and Location of Hea	th Care Facility (if i	known)	
CATENTON H	ouse / 1	3EIGH	10N, 44
Vature of Complaint		•	
Substandard Medical C Professional Misconduct Sexual Misconduct Rade or Discourteous E Impaired by Alcohol or	t Jehavlor		Drug Dealing Criminal Conviction Patient Neglect/Abandonment Unlawful Discrimination Billing for Services Not Rendered
Sexual Misconduct  Rade or Discourtectus E  Impaired by Alcohol or  Impaired by Mental or  Pailure to Provide Med  Overcharge for Medica	Ernotional Jilness icai Records	000	Failure to Supervise Staff False Advertising Fraud
Other			·

Please do not write below this line.

#### ADDENDUM TO COMPLAINT FORM

- Referred by MGH to Crittenton for pregnancy termination, as fetus was not viable per MGH recommendation. MGH assured me I would be given anesthesis or a sedative for pain management.
- Allergic to some forms of general anesthesia, which was reported to Crittenton in advance of my procedure.
- 3) I was told that Setinol would be used at Crittenson, as it is not a general anesthetic agent. Told to bring records "just in case."
- 4) Abortion to be performed at 6 weeks, 5 days into term.
- 5) Waited in waiting room from 7:45 AM until 11 AM. Was informed just before procedure that no anesthesia or pain management drugs would be provided, but the operation would be only "slightly uncomfortable, similar to menstrual cramps." As they looked at my medical records, I was told that this would be a cake-walk compared to my surgeries in the past.
- 6) Made to undress, give urine sample, then sit in tiny room with 5 other girls for an additional hour.
- 7) When asked into procedure room, made to wait again while Oricin located nurse to easist.
- 8) Placed in stirrups, speculum then roughly inserted.
- 9) Lidocaine injected and dilators shoved into cervix simultaneously, which meant lidocaine had not been given time to act.
- 10) Aspirator roughly shoved in and out until uterine liming removed. Again, lidocaine still hadn't set in, so extreme pain. Curette scraping as well.
- 11) Worst pain ever experienced, and I have been through some extreme surgical procedures and never complained. Screaming to stop and give something for the pain. Broke into sweat, passed out, vomited.
- 12) Carried off table, sanitary napkin shoved between legs. Continued vomiting and sweating.
- 13) Jar full of blood and presumably fetus was paraded in front of me as they left the room.
- 14) Had to urinate and Orkin follows me in and uses stall next to mine. Too weak to protest this further humiliation and violation.
- 15) Orkin then changed in doorway in my full view.
- 16) I continue to have nightmares to this day. I feel raped. Do not let this happen to anyone else.

#### BOARD OF REGISTRATION IN MEDICINE

ROOM 1507 -- 100 CAMBRIDGE STREET **BOSTON, MASSACHUSETTS 02202** RENEWAL APPLICATION 1986-1988

#### IMPORTANT - READ, COMPLETE AND SIGN -

PURSUANT TO M.G.L. C. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO. OPTIONAL

YOU MUST SIGN BELOW

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THIS	FFE	DATE TO BE RENEWED	LAT

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BORIS I ORKIN

DO NOT WRITE BELOW THIS LINE

YOU ARE REQUIRED TO COMPLETE ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.) IF YOU ANSWERED "YES" TO ANY OF THESE QUES-TIONS, YOU MUST CHECK THIS BOX:

REDACTED COPY
PLEASE USE THE ENCLOSED RETURN ENVELOPE

THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A \$100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.



**PAYABLE TO:** 

**COMMONWEALTH OF MASSACHUSETTS** 

P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

3500600517011 011586 10000000004

Print Name: BORIS I ORKIN	Date of Birth: _		+ . *
Medical School: <u>IVANO-FRANKOVSK</u> , <u>USSR</u> Date of G You must read the instructions enclosed with this form to answer questions 1-12.			
1. Principel Specialty(ies): <u>OB/6YN</u>	Principal work setting:     A. Principal business address	RESIDENT,	OB /64N
3. Home address; 5 867 FGS	736 CAME	KIDGE ST.	
5. List all hospitals at which you have currently effective privileges: 51. ELIZA.	BETH'S Hosp. BOSTON	, MA 021	35
6. States other than Massachusetts in which you are Ilcensed to practica:			
7. Heve you been a defendant in any malpractice suit commenced since 10/1/83?			YES NO
Have you been a defendant in any criminal proceeding other than minor traffic offer     Has any disciplinary action been taken against you in the last ten years, by any government medical association (international, national, state or local)?		saith care facility, or by	iny
16. Has your privilege to possess, dispense or prescribe controlled substances ever bec	en suspended or revoked in this state or a	iny other?	
11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows:	100 house CAT	I ,	
12. I am an active . Vinactive practitioner. (Check one) I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE I	INFORMATION IS TRUE.	Qui	 SNATURE
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#### BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1967-1989

LICENSE NUMBER		PAY THIS	FEE	DATE	DATE TO BE MENENED		LATE FEE	
COOL	TYPE	REGISTRATION NO.	TAUCMA		MO	ΔA	ΥR	
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BORIS I ORKIN

NUMBED TO COMPLETE THE GLIES-AND ON THE REVERSE SIDE OF THIS . (SEE THE ENCLOSED INSTRUC-TIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS
THROUGH 24, YOU MUST CHECK THIS BOX:

PLEASE USE THE ENCLOSED RETURN ENVELOPE



COMMONWEALTH OF MASSACHUSETTS N WEST STREET, and PLOOR BOSTON, MASSACHUSETTS 62111

PLEASE PRINT ANY NAME OR ADDRESS. CHANGES BELOW

	_		
1. Print Name: BORIS T. ORKIN	2. Date of Birth:		·
2. Medical School: TUANO-FRANKOUSE USS R M.D.? D.O.? (Check One.)	NACEF	л дау	TEAR
4. Country where Medical School located:USSR 8. Date of Graduation:	UNE 1992		
6. American Specialty Board Cartified?  (Check if yes.)			
Which Boards?	<u></u>		
	RESIDENT		
9. Home address: 10. Principal business address	St. ELizabe	sth's He	250
736 CA	MBRIDGE ST	BOSTON	02135
1. List all nospitals at which you have ourrently effective privileges: ST. SLIZG 6 GTH'S. Hos	1. OF BOSTON		T
2. List all hospitals at which you have held privileges in the past 20 years: LIALTHAM HOSP, MA.	MOSCOCO CITY	TEACH	fost
3. States other than Messachusetts in which you are presently licensed to practice:			
	<del>'''''                                </del>		
4. List any other states where you were previously licensed to practice:		YES	NO.
E. Has any medical malpractice claim been made against you in the lest ten years (whether or not a leweult was filled	in relation to the claim)?		
8. Howe you, at any time, been a defendent in any criminal proceeding other than minor traffic offenses?		7	
7. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten y suthority, by any bospital or health care facility, or by any professional medical association (international, nations.)	ears, by any governments!	7	
I. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied or here you been gailed before or warned by this state or any other jurisdiction including a federal agency, at any	, reattleted, surrendered,	†	
B. Have you over withdrawn on application for medical licensure or been denied a medical license for any reason?		1	
3. Have you ever had any mental filmes which has impaired your ability to practice medicine or to function se a stud	ent of medicine?	†	
1. Have you over had an organic liness which has impaired your ability to practice medicine or to function as a stude		4	
2. Are you now, or have you been in the past, dependent upon alcohol or drugs?		†	
		†	•
Have you ever, for any resson, test American Specialty Board Certification?     Have you been denied recertification by one or more specialty boards?     if yes, which one(s)?		- -	
If you writer overlay?  If have completed my C.M.E. requirements in the two years ending on the renewal data as follows:	THE ORINA	RESIDE	DAY-2
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HERIEBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BAI UNBUANT TO CHAPTER 475 OF THE ACTS OF 1986, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE B ILE CHARGE FOR MY SERVICES.	ENSFICIARY MORE THAN TH	E MEDICARE R	MEABON-
URBUANT TO M.G.L. a. 625, § 46A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST ISNOWL ETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW, PLEASE NOTE: THIS APPLIES EVEN IF YOU SEE	où Orkin	9 44 500 A	
	And a signature	1987	,
OATE:	APLIL Y	TART	



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Registration No. Status 51701 I		12/89 A2-21	S. S. J. S.		
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. Make a copy of that form who a . Enclose the \$150 renewal fee i	y means of a certified	i check, money order or per	nonel check made pays	ple to the Commonwealth o	/ Africachuselle.
	-				
1. a) Name (LAST:)			(FIRST:)	RIS	(M.L.:)
1. b) Other Nume(s), if any, that	you were ever floorer	ed under:			
2, a) Address (Melling):_			<u>.                                      </u>		
2. b) Address (Home):_					
S. D) Macres (Lexus):			<del></del>	<del></del>	
		100 t 00	TANAL		<del></del>
2. c) Address (Business):	<u>∽w ñn T</u>	Dept Ob	10-4 10	A74 3	
	TO BERGE	EN ST, NE	WARK, N	7 ///03	
2 d) Telephone (Buelness): (_2	01)456-6	Ocu Extension 735	2. a) Telephone (Ho	orne) (Optional): (	
3. Date of Birth (MO/DA/YR):		4. Sex: MALE I FEM	ALE 6, 800	ial Security No. (Optional):	
5. a) Medical School Code (See	Table 11: 0 11 < 2			•	
•		e: M.D. / D.O			<del></del>
S. b) Year Graduated: 72					
3. d) Country: U.S Canada	n Code if Other (i	See Table 2): LLS #6	100, write Name:		
7. Work Setting (Circle and India	nate Pageage(%) of Pop	estos Timel:		•	
	30· %	15 Private Office	*	20 Partnership/Group F	Yactios %
25 Clinic	<u></u> -	30 Montal Health Center		35 Nursing Home	<u> </u>
40 HMO Facility	*	45 Educational Institution	×	50 Medical Society	w
56 Government Facility	<u> </u>	60 Plant/Commercial Set	ting%	99 Other	<b>%</b>
		, 11 - 4 Day day a day and Thomas			A Silvano I In Januar Basin
8. Professional Activity (Circle a 10 Resident or Fellow	100 %	20 Preside Involving Di	rant Bullant Cara		r) Mass. Lio. Issue Dete s your wall certificate)
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2. Specialty Code (See Table 3)	: QB & Percent of		Specialty Code:	Percent of Practice Time	:%
#OS, specify:					
10. a) Are you American Special	ly Board Certified? (Y	(/N) <u>N</u> 10.6) # VES, of	cie which (Board(S):		
Al Board of Allergy &	Immunology	NM Board of Nucle	ar Medicine	PS Board of Plastic	
A Board of Anasthe			trice & Gynecology	PM Board of Prever	
CRS Board of Colon &		OP Board of Ophth		PN Board of Payohi R Board of Radio	letry & Neurology
D Board of Dermato EM Board of Emerger		OS Board of Ortho	• •	8 Sound of Surger	••
FP Board of Family F		PA Board of Pathol	· •	T8 Board of Thorse	•
M Board of Internal		PE Board of Pedial	rios	U Board of Urolog	Ŋ
NS Board of Neurolog	ploat Surgery	PMR Board of Physic	el Medicine & Rehabilit	ation	
i (. a) Hospitals at which you ha	eviscelle <u>vimenuo</u> ev	privileges and other Health	Care Facilities with whi	ich you are associated; Pea	pent of Practice Time at eac
(See Table 4.)					
Facility Code:	<u>*</u>	Facility Code:	<b>%</b>	Facility Code:	<u>%</u>
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hereby certify under the pane	ities of perjury that:	all information on this for	n-froat and back and i	(#) etteched names	io truo.
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12	NV	_			

Massachusetta Board of Registration in Medicine 1969-1991 Renewal Application,	Page 2 of 2 2
Fill in name and number. Physician Last Name: ORKIN	Registration No.: <u>51701</u>
12. a) Other States where you are now licensed to practice (Abbreviate):	
13. I am applying to be registered with the following status: ACTIVE   NACTIVE   NACTI	mor questione 14. a) through c).
14, a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: (Fill in # of hours or Category I: hrs., Category I: hrs., (Red-Management: hrs.); Residency Program in: LI PA D Walver Requested (You must till out a separate Walver Form.)	F. 2 ' 00   F.A. M. (Angl.)
14. b) My medical malpractice incurrence is covered by INSURANCE CARRIER LETTER OF CREDIT V. If explicable, oh incurrent incitation feating Letter of Credit:	
Alternatively, Indicate an follows: I arm registering with ACTIVE status, but I arm not covered by medical malpractice freeze NOT INVOLVED IN DIFFECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how) W/ L.C.	
14. a) Percent of Presides Time in Manachusetts: 100 %	MASS. July 1,89
Questions 15 through 17 refer to the gent four ware only. Check either YES or NO (not N/A) to gent question. Provide details as	r Porm 18A, attached.
15. Has any pending or new medical malpractice claim been made against you (whether or not a lewest was filed in relation to	she claim)?
18. Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offenset	
17. Are any formal disciplinary charges pending or has any disciplinary sollon (as defined by Board regulations—Bas instruction against you by any governmental authority, hospital or other health care facility, or professional medical association (international, state of local)?	o) been telets sellonal,
If you answered "YES" to question 16, 18, or 17 provide details on Form 18A, attented.	
alloggy persongs before no and a perfect of a source and a person and a perfect of the perfect o	<del>*************************************</del>
Questions 18 through 24 rules to the <u>next four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details in	
16. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revolated, deried, resistated, a here you been deled before or been warmed by this state or any other jurisdiction including a federal agency?	urrendered, or
19. Here you withdrawn an application for a medical license or been denied a medical license for any reason?	dissessifi to l'arter regar principales su req
20. Have you had any mental litrace which has impaired your ability to practice medicine or to function as a student of medicine.	167
21. Have you had an organic liness which has impaired your ability to practice medicine or to function as a student of medicine	<b>**</b> **********************************
22. Are you now, or have you been in the pest, dependent upon alcohol or drugs?	
23. Have you, for any reason, lost American Specialty Soard Certification?,	
24. Have you been denied recertification by one or more specialty boards? If YES, flet Board(s):	4-10-12141484414144444444444444



# Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 62111 1991-1993 Physician Registration Renewal Application

gistration No. Status	Fee Renoval Date		For Office Use Only
Dr. BORIS	\$150 06/12/91	<del></del>	M.R.
OF BURIS	I OKKIN		BL APR 1 7 1991
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alore proceeding, please read th		ar 1.51-1-55-a.y.	
inawar all non-optional quastions	completely. (The instructions spe	ally which questions are op	donal)
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Telephone Number:			
Home.	Business	Home:	_ Business: (6/7) 592-3000
	(201)456-5000		
Medical School CodeR US 30	Year Graduated? 2 Degree	MD School Code:	Year Gratisated: Degree (MD/DO):
Name of School:		If 90009, write \$	lahaal:
van-frankovskij	Medical Institute		
Other States where you are now			
States where you previously were	e Noensed to practice ( <i>Abbr</i> ):		
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Specially Code(s) (See Table 5):			
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Are you American Specialty Boar	nd Certifical 2 (VAIX) 7 ht 14	YES, Enter Codes:	T
Are you American opeciaty soul  Code:	in common (tudy (m) it	ied, einif <b>vivis</b> .	Code:
Code:		•	Code:
Drug License Number(s) (if any) [	igotionell: s) Federal (DFA)		b) How many DEA nos. do you have?
na de manue i compactat fil milit	c) State (MA) #M	<del></del>	of the state of th
I have completed my C.M.E. requ			YES V Walver Requested bur license will be renewed.) See instructions for CME

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER / or (b) LETTER OF CREDIT
Liet Insurer: T.U.A
Alternatively, incluses as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice incurance because I am (Chast am (I) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:
(State how otherwise exempt):
11. Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to these facilities where you have admitting privileges (AP).
Facility Code: 8 / (AP) Facility Code: / (AP) Facility Code: / (AP)
Facility Code: 14/4(AP) Facility Code:/_(AP) Facility Code:/_(AP)
# gpg, unite Name(s):
Additional Hospitule at which you <u>proving to the past 4 years.</u> (See Table 5.)
Facility Code: Facility Code: Facility Code: Facility Code:
# 998, pelle Name(s):
12. Post Graduate Training in Messachusetts (MA) (See instruction bookist.)
a) Are you ourrently in a post-graduate training program in MA as a resident or clinical fellow? Yes No (Callit one.) b) If you are in a MA program, are you a: I) Resident II) Clinical Fellow or III) Research Fellow ? (Check as.)
c) How many hours per typical week do you spend in this MA post-graduate training program?ins./wk. in MA.
18. Care of Patients in Massachusetts (MA) (See instruction booklet.)
a) How many hours per typical week are you currently involved in outpetient care in MAY 50-60 tre. Mrk. in MA.
b) How many hours per typical week are you currently involved in inpatient care in MAY 40 hrs./wk. in MA.
14. Principal Work Setting. a) What is your principal work setting? (See Table 6) 2_ Q.
Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to seek question. Provide details on Form 15A.
Claire is the instruction having by advisored tentangers
Refer to the instruction backlet for additional information.  Yes Ma.
Yes He 15. Her any pending or new medical malpractice claim been made against you (whether or not a lawruit was find in relation to the claim)?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawsuit was field in relation to the claim)?  16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
Yes He 15. Her any pending or new medical malpractice claim been made against you (whether or not a lawruit was find in relation to the claim)?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?  16. Here you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?  16. Here you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?  16. Here you been a detendant in any pending or new oriminal proceeding other than a minor traffic offense?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?  16. Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?  16. Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?  16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawruit was filed in relation to the claim)?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?  16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
15. Here any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
15. Her any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?  16. Have you been a defendent in any pending or new oriminal proceeding other than a minor staffic offense?



#### Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts **62**111 1993-1995 Physician Registration Renewal Application

Registration No. Status Fee Renewal Date Late F . 51701 ACTIVE \$250.00 06/12/93 \$35.0	CHITOCHOE OF MARKET AGGREGAT
Medling Address:	Address (Mailing):
BORIS I ORKIN, M.D.	City/Town:
	StateCountry Code (See Table 1)
	Charge Cods (see Lage 1)
Directions: Steple check to bottom of form. Add into fee if necessar	7. Par Cille Se Suit
• Questions 1-8 include information from Board files. Please correct as a	accessery in the boxes
provided on the right hand side of the page.  • Refere proceeding, please read the instruction booklet. Some questions	are optional.
- Make a copy of this form and all attackments for your own records	- you will need copies
for condensialing and other purposes. The Board will charge a fee for Buckons the \$250.00 masswal fee by means of a certified check, money	and an amount of the state of t
payable to the Commonweakh of Massachmetts.	Order or henomy design mans
Pre-Printed Information	Corrections of Fre-Printed Information
<del></del>	
1. Other name(s), if any, under which you were licensed.	Name.
2. a) Address (Home):	Address (Hottes):
-	Cny/Town Zho
	Country Code. 1999 prost Country:
b) Address (Business).	Country Code. If 999 print Country.  Address (Brossess). II SO SERCON ST. SUITE 5B
493 WESTERN AVENUE	City/Town: BROOKLINE MA 02/46 Country Code H999 print Country
IRISON BUILDING, 4TH FL.	County Court a /// p.a. county.
LYNN, 4A 01904	
	Date of Birth (M/D/Y) Sex (M/F):
3. Date of Barth: Sex: M Lie Issue Date. 10/14/33 SS#	Lac. Issue Date (M/D/Y)
Telephone Number	Telephone Number:
Home Busmons	Home ( ) Business (61) 277-0090
(617)592-3000	Full Name of Medical School.
4. Name of Medical School  Iyan-Frankovskij Medical Institute	
TABIL LIBITED SKIT TO LOCK STORE STO	Year Graduated: Degree (MD/DO)
Year Graduated 72 Degree: MD	
5 a) Other states where you are now licensed to practice (Abbr).	
<ul> <li>5 a) Other states where you are now licensed to practice (Abbr)</li> <li>b) States where you proviously were incessed to practice (Abbr)</li> </ul>	
	Code Hours per Week at Mess
6. Specialty Code(s) (See Table 2)	
Code Hours per Week m Mass	
one 60 Opstetrics and Gynecology	If OS, print specialty
0	
7. a) If you are currently American Specialty Board Certified, enter Code	s: (See Table 3) Code Code
Code: Code	
b) If you previously were American Specialty Board certified, but are a please enter codes of prior certification: (See Table 3)	
Code: Code	Code. Code.
8 Drug Lucense Number(s), if any a) Federal (DBA)	Pederal (DEA):
b) State (MA)	State (MA)
9 I have completed my CMB requirements in the two years preceding my You most fill out a separate Warver Form. The warver must be granted	/ renowal dam: Xes

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

OPVINI TO THE
PRINT NAME AND NUMBER: Physician Last Name: ORKIN Registration Number: 51701
10. Activity Status: I am applying to be registered with the following status: Active Inactive
I hereby carrily that if requesting functive status, I will not practice medicine, including writing prescriptions, in Massachusetts.
11 My medical mathematics insurance is covered by (a) INSURANCE CARRIER V or (b) LETTER OF CREEKT
List Instant:
Alternatively, indicate as follows: 1 sm registering with ACTIVE status, but I am not covered by smelled sonlycaction insurance because I am
(Check One): (1) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS: (8) OTHERWISE EXEMPT:
12. Current Houlth Care Pacifity Affiliations. Supply the codes from Table 4 and place a check mask ment to these facilities where you have
education privileges (AP).  Peolity Code: / (AP)
Positivy Code: / (AP) Positivy Code: / (AP)
17999, print manu(s):
Additional hospitals at which you previously held privileges and other hoslik care facilities with which you were associated in the past 2 years.  (See Table 4)
Pecility Code: Facility Code: Fecility Fecilit
H'999, write mane(s):
13. Are you correstly in a post-graduate training program m MA as a resident or climed follow? Yes No (Check one)
14 a) What m your principal work scatting? (See Table 5) 1 5
b) Care of patients in Massachusetts (MA) (See instruction hocklet.)  i) How many hours per typical week are you currently involved in conputers care in MA? 20 km/wk in MA  ii) How many hours per typical week are you currently involved in inputions care in MA? 10 km/wk in MA
Questions 15 through 23 rofter for the past two years only. Check eather YES or NO (NOT N/A) to each question.
Provide datas on Form 15A for all YES suswers. Refer to the instruction booklet for additional information.
IN THE PAST TWO YEARS: NO
15 Has any medical malpractice clasm been made agamst you, whether or not a lawsuit was filled in relation to the claim?
16 Have you been charged with any criminal offense, other than a minor traffic violation?
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, reveised, denied or restricted by any state or federal agency?
19. Have you walkdrawn an application for a medical license or been demed a medical houses for any ressent
20. Have you had any mental silness which has unpaired your ability to practice medicine or to function as a student of medicine?
21. Have you had an organic illness which has impaired your shility to practice medicine or to function as a student of medicine?
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a suscharge on your coverage?
• Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare baneficary more than the Medicare ressonable charges.
· Personnt to G.L. c. 62C, sec. 49A, I hereby certify under the possities of perjury that, to the heat of my knowledge and helial, I have
filed all Meanschnestis state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.
· I hereby certify that I will fairfff my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. \$1A.
<ul> <li>I hereby curtify under the penalties of perjury that all information on this form and Ferm 15A is true.</li> </ul>
Bokm, M. D. 14,8,93

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

Registration No. Status Fee Renowal Date Late Fe 51701 ACTIVE \$250.00 06/12/95 \$25.0	•
Mailing Address: BORIS I ORKIN, M.D.	Address (Malling):
	City/Town:
	State:
	Country:
Directions: Before proceeding, please read the instruction booklet. Some	questions are optional.
<ul> <li>Failure to renew in a timely manner will cause your license to lapse a ability to practice medicine in the Commonwealth. (See enclosed letter</li> </ul>	
• Add late for if necessary.	
<ul> <li>Make a copy of this form and all attachments for your own records credentialing and other purposes. The Board will charge a fee for each co</li> <li>See instructions on detachable coupon at bottom of this page.</li> </ul>	
The same of the sa	BOARD OF REGISTRATION
Pre-Printed Information	Corrections of Pro-Printed Information
1. Other name(s), if any, under which you were licensed:	
	Neme:
2 Business Address:	Address:
1180 BEACON ST.SUITE 5B	City/Town:
BROOKLINE, MA 02146	State: Zip:
	Country:
9 Warra - # Walada	Date of Birth (M/D/Y): Sex (M/F):
3. Date of Birth: Sex: M	Lic. Issue Date (M/D/Y): SS#:
Lic. Issue Date: 10/14/83 \$84:	
Trans Phase Western West	Home: ( ) Businese: ( )
Home Phone Business Phone	
(617) 277-0090	Pull Name of Medical School:
4. Name of Medical School:  Tvan-Frankovskij Medical Institute	
IANU-ALMUNDART] Wedical Institute	V
Year Graduated: 72 Degree: MD	Year Graduated: Degree (MD/DO);
5. a) Other states where you are now iloensed to practice (Abbr): Mar	
b) States where you previously were licensed to practice (Abtr):	
	Code III
6. Specialty Code(s) (See Table 1):	Code House per Week in Muse.
Cods Hours per Week in Mass.	
OBG 60 Obstetrics and Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (	Sen Table 2)
Code: Code:	Code: Code:
B. Drug license number(s), if any:	
	F =
b) Massachusen	Poderal (DBA);

· I hereby certify that if requesting Inactive status, I will not practice medicine, incind

PRINT NAME AND NUMBER: Physician Last Name:	Registration Number:
10. a) Current health care facility(ies) at which you have completed the credentialing process for the	
codes from Table 3 and place a check mark next to those facilities where you have admixing privileg  Facility Code:	ns (AP).
	rility Code: /(AP)
• • • • • • • • • • • • • • • • • • • •	cility Code: / (AP)
If 999, print name(s):	
b) Additional hospitals at which you previously held privileges and other health care facilities with the Party 2)	th which you were essociated in the past 2 years
(See Table 3)  Facility Code: Facility	Code: BeoBiss Code:
If 999, write name(s):	
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Cradis	If smilloshle short one
List Insurer: MMPIA	ii apparating times top.
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by met	fical malpractice insurance because I am
(Check One): (i) Not involved in direct/indirect patient care in Massachusetts:	(ii) Otherwise exempt:
State how otherwise exempt:  12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow?	Yes No (Check one)
13. a) What is your principal work setting? (See Table 4)	
b) Care of patients in Massachusetts (See instruction booklet.)	
i) How many hours per typical week are you currently involved in outpatient care in Mass?	50 hm/wk
ii) How many hours per typical week are you currently involved in impatient care in Mane?	10 brajwk
c) Approximately what percentage of your patient care hours are in primary care?	10
(See instructions for definition of primary care.)	20 .
Questions 14 through 24 refer to the past two years only. Check either YBS or NO (NOT N/A Forms R-1 and R-2 for all YBS enswers. Refer to the instruction bouldet for additional infer	
IN THE PAST TWO YEARS:	YES NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet	
adjudicated, whether or not a lawsuit was filled in relation to the claim?	
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated whether or not a lawsuit was filed in relation to the claim?	i or otherwise resolved,
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to pra-	
fessional conduct in the practice of medicine, been filed against you by a patient, or been settled,	
1000/V017	
17. Have you been charged with any criminal offense, other than a minor traffic violation?	
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or stand governmental authority, health care facility, group practice or professional society or association?	
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or st	· ·
or restricted by any state or federal agency?	
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surch	
have you voluntarily restricted, limited or terminated your instrumes coverage in response to an in liability insurance provider?	quiry by a professional
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ab	
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your	•
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reas	
condition?	
25. I have completed my CME requirements in the two years preceding my renewal date: Yes	
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by a renewed. See instructions for CME requirements. Do not submit documentation of your CMEs w	
Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary me	
<ul> <li>Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the paint and penalties of parjury to</li> </ul>	
I have filed all Massachusetts state tax returns and pald all Massachusetts state taxes that are requ	rien, or one more of my amorridge and politic, sired under law, NOTE: This sends
even If you reside out-of-state or out of the United States.	
<ul> <li>Parament to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abo G.L. c. 119, sec. 51A.</li> </ul>	nte or neglect of children as required by
. I hereby certify under the point and penalties of perjury that all information on this form an	d Forms R-1 and R-2 is true.
Signature BOKES, M.D.	Date: 4,4,95
The state of the s	
$oldsymbol{l}$	



#### Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3006, ext. 320

本一十

## Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.  Copy this form and all attachments for your own records; you will The Board will charge a fee for each copy.	nijedicapies for credentialing and other purposes
• Remit \$250.00 for renewal fee. • Add late fee of \$25.00, if necessary \$ 200 2 A SS	Return renewal application in GREEN envelope.     Enclose check with coupon in BLUE envelope.
Fill and	Ancies casca was coupon in naces enverope.
Registration No 51701 Renewal Distance Co. 1	
(Chair and Vone)   Inactive *(see below)   Do not wish	nee instructions) a to renew 5 597
2 Other Name(s), if any, under which you were licensed	Corrections (type or print)
3 AMailing/Home Address	Other Name(s):
,	Mailing Address
BORES & OPERN M.D.	City/Town State
	Zip Country
BBusiness Address:	Other Address.
BROOKLINE, MA 02146-3806	Crty/Town State
	ZipCountry:
Home Phone. Business Phone (617) 277-0090	Home ( ) Busmess ( )
4 A) Date of Birth C) Sex M B) Lic Issue Date 10/14/83 D) SS#	Date of Buth (M/D/Y)/_   Sex (M/F)  Lic Issue Date (M/D/Y)/_   SS#
5 A) Name of Medical School	Full Name of Medical School
Ivan-Frankovskij Medical Institute	
B) Year Graduated 72 C) Degree: MD	Year Graduated Degree (MD/DO)
6 Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass.	Code(s) Hours Per Week in Mass
OBG 60 Obstatrics and Gynecology	If OS, Print Speculty.
7 Current American Board of Medical Specialties Certification	n (See Table 2)
Code Code	CodeCode
B) Drug License Numbers, if any A) Federal (DEA) B) Massachusetts	Federal (DEA)
A) Other states where you are now licensed to practice  Abbr NJ  B) States where you previously were licensed to practice	Abbr
Abbr	Abbr

<sup>\*</sup>If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Manuschusetts

PHYSICIAN INFORMATION	τ.	OT.	WTN:	
BORIS rst Name M	iddle Initial	Las	Name	Suffix
ake changes to name here			ganggén mi 400a shikit ta'uu guqog yog 2000aa2u ba'uu sorpang	
ass License # 51701			First Issue Date	10/14/89
consc Status Active				
	<u>Hio</u>	spital Affiliation		
180 Beacon St. Ste 5B brookline, MA 02148-8806 J.S.A. 317) 277-0090	No Far Ne	Elizabeth's Medical Certh Shore Medical Centulkner Hospital wton-Wellesley Hospita	ier-Salem Hosp al	
	Be	th Israel Hosp	of Boston	
lake address corrections here:	Make an	n corrections to altime he	me:	·
ELAC CONTROL OF THE C	sreung ur	add Beth	Israel Ho	spitul
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N	1:	**-111:	,	
Insurance Plan Affiliation:	,	Held in Other States:	Accepting New Pat	ients? Tyes No
	NJ	***************************************	al Center Center-Salem Hosp Sepital Hosp. of Boston We here:  Accepting New Patients?   Yes   No Accept Medicaid?   Yes   No  Part 1999  End 1999  End RTIFICATION d Name: d Name:	
	(Please	correct as necessary)		
·	(1 10000		•	
EDUCATION & TRAINING				
an-Frankovskij Medical Institute		MD		—
ical School		Degree	<b>D</b>	ate
e corrections here !. Lizalith's Mul CI	×	1405		
dency Prispram(s)		Start	#+++1P**********************************	
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dency Program(s)		Start		
SPECIALTY		BOARD CERTIF	<u>ICATION</u>	
ary Specialty: Obstetrics and Gyne	ecology	Certifying Board Na	me:	
ndary Specialty:		Certifying Board Na	me:	
e any corrections here:		Make any correction	s here:	
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BOARD DISCIPLINE					
Final Decisions and order		usetts Board of R	egistration in Medici	nc.	
Nature		<u>Date</u>	•	<b>Board Action</b>	
NONE	•				
740.00					
•					
. HOSPITAL DISCIPLI	NE				
Hospital		Date		Disciplinary Action	
NONE					·
None			•		•
			•		
of complaint No	いし				***************************************
. MALPRACTICE					-220-4 19-2- <u>2</u> 4 19-6/119-24
Details of claims paid for	Dr. ORKIN		No.	of Years in Practice: #	
Date NOVE A	mount Paid 0.0000		Basis for Complaint		
Date A	Amount Paid		Basis for Complaint Basis for Complaint	**************************************	************
DateA	mount Paid		Basis for Complaint	48 *** ********************************	***************************************
DateA	mount Paid		Basis for Complaint	Digentagent physic to the billing and the banks of the ba	*********************
Date	mount Paid		Basis for Complaint	** Torrogrammerer - 1 predictions and passance datas and Tables Sections of the section of the s	1 a par dus mest ant de 201 11 54 6634
. PHYSICIAN HONOR					
Please enter any peer-revie professional recognition yo		ich you have cont	ributed and any awar	ds for community service or	
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Awards, H	lonors			Publications	•
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Note: Please return the survey in the enclosed envelope to: Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103



Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3006, ext. 320

Physician Registration Renewal Application

Before preceding, please re • Copy this form and all attachments for your own feecies, you will	and the instruction bookist.
	1 999
	APR 2 1999 Return renewal applications Renewal page 2 1999 Return renewal applications Renewal Date 06722/1399 Current Status Agt 1
• Add inte fee of \$25.00, if necessary:	minorate made with opening management and the second
Registration No 51701 Renewal Date. 06/12/3	1 Current Status Acti
Copy this form and all attachments for your own focoids, you will Remait \$250.00 for renewal fee. Add into fee of \$25.00, if necessary  Registration No 51701  Resewal Dafe. 067422  Inactive Reservations Reservations Reservations (See Code Code.	
Remain \$250.06 for renewal fer. Add late \$40 et \$25.00, if necessary	
	Please make corrections (type or print)
2 Oute Manager, is may, those whole you well necessor	
3 A) Mailing/Home Address:	Mailing Address
· · · · · · · · · · · · · · · · · · ·	City/Town State
	Zip Country
B) Business Address:	Other Address
	City/Town State
	ZipCountry
BROOKLINE, MA 02140-3606	
Toma Bhana	
	<u></u>
Dustriess Livric (911) 511-0030	
	SS#
5 A) Name of Medical School:	Full Name of Medical School
Ivan-Frankovskij Medical Institute	
B) Year Graduated 1972 C) Degree MD	Year Graduated Degree MD, D.O.
OBG 60 Obstetrics and Gynecology	
	Table 2) Code
	Rederal (DRA)
·	
ALC I	Abbr
Remain 3250,00 for renewal fice.  Add late fee of \$25.00, if necessary  APR 2   999  Return renewal applications  Eachose check with composite and other fee of \$25.00, if necessary  I Current Status  Age times a proper of the composite and the co	

<sup>&</sup>quot;If requesting <u>Inactive</u> status, you agree not to practice medicine, including writing prescriptions, in <u>Massachusetta</u>

P	RINT NAME AND NUMBER: Last Name ORKIN Registration Number 51701 -
10 th	Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply a codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to
E/c	centry Code 441/ (AP) 900 % Facility Code 25 / V (AP) % Facility Code 75 / V (AP) %
T#	000 month name(s) Paggo Adaptictes (10%)
11	My medical majoractice insurance is covered by a) X Insurance Carrier b) Letter of Credit
	Name of Insurer CRICO Alternatively, indicate as follows
ľa	
	Not involved in direct/indirect patient care in Massachusetts b)
	ease texplain exemption
	Are you currently in a post-graduate training program in Massachusetts as a resident or climical fellow? (check one) [ Yes [ No
13	A What is your principal work setting? (See Table 4) 15 10
	B Care of patients in Massachusetts (see instruction booklet)
	2) What is the approximate percentage of your patient care hours in primary care? 10_%
PA	RT A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide alls on Form R for all YES answers except for question 22. Refer to the instruction is ackiet for additional information and instructions. You must answer ALL questions, or this form will be returned to you and your beams renown! may be delayed.
,32	
1.4	
17	settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
	In health care facilities at which you have completed the evidentialing process for this provision of patient care Supply from Table 3 and place a check mark next to those health care facilities where you have adminting privileges (AP). Next to the approximate percentage of patient care hours that you provide in each facility.  dot \( \frac{H}{H} \cong \frac{H}{A} \) (AP) \( \frac{AP}{AP} \) \( AP
16	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?
	Have you been charged with any criminal offense, other than a minor traffic violation?
	Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
19	Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
	Have you withdrawn an application for a medical license or been denied a medical license for any reason?
21	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
22	Caraci Contract Contr
C	Class America Ladization (co
•	Pursuant to G.I. c. 62C, 8 49A, to the best of my knowledge and belief. I have filed all Massachusetts state tax returns and paid all
	Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A
•	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true
ø	201/= 1
OIZ	nature Date



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

# Physician Registration Renewal Application

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

<ul> <li>Remit \$250.00 for renewal fee.</li> <li>Add late fee of \$25.00, if necessary</li> </ul>	<ul> <li>Return renewal application in GREEN envelope.</li> <li>Enclose check with coupon in BLUE envelope.</li> </ul>
Please review carefully the following informations as required	tion for accuracy and completeness. Make any corrections or
1 Current Status Active Registration 1	No 51701 Renewal Date 06/12/2001
	e of the following boxes to indicate your new status (Check only one)
Active Retiring (see instructions)	☐ Inactive (see instructions) ☐ Do not wish to renew
2 Other Name(s), if any, under which you were hoensed	Please make corrections (type or print)
	Other Name(s)
3 A) Marling/Busmess Address BORIS I ORKIN	City/10wiiState
	County
	Business Address     80 Blace 51. STE 5B City/Town BROKLAS State AAA Zip D2446 Country USA
<u> </u>	Busmess Telephone ((12) 277-0090
	Home Address
Home Phone	City/Town State Zip Country Home Telephone
Business Phone	PLEASE NOTE: No P.O. Box addresses for home or business addresses.
4 a) Date of Birth b) Sex M	7 Current American Board of Medical Specialities Certification (See Table 27—Code Code
c) SS# 5 a) Name of Medical School.	8 Drug License Numbers, if any a) Federal (DRA)
b) Year Graduated. Medical Institute 1972 Degree M D	b) Massachmeetts  9 a) Other states where you are now becaused to practice (Abbr)
6 Speciality Code(s) (See Table 1) Code(s) Hours per Week in Mass	b) States where you were previously licensed (Abbr )
OBG 0 Obstetrics and Gynecology	
O Current health care facilities at which you have completed the codes from <u>Table 3</u> and place a check mark next to the Next to each facility, write the approximate percentage of	d the credentialing process for the provision of patient care (Supply hose health care facilities where you have admitting privileges (AP) f patient care hours that you provide in each facility)
calaty Code 441/ (AP) 00 % Facility Code. 5 calaty Code (AP) 0 % Facility Code.	3 / / O (AP) % Facility Code / Q / (AP) 0 %

1	RINT YOUR LAST NAME OKKIN LICENSE NUMBER: 51	<u>+01</u>	
		<b>J</b>	
11	My medical malpractice insurance is covered by a) X Insurance Carrier b) Letter of Credit	<b>;</b> •	
	Name of Insurer CRICO Alternatively, indicate as follows	•	
I	am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)		
2)	☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt		
P	ease explam exemption	<del></del>	_
12	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one	Yes 🗌	N
13	A What is your principal work setting? (See Table 4)		
	B. Care of patients in Massachusetts (see instruction booklet)		
	1) Average weekly hours involved in a) outpatient care 25.46 hrs/wk b) impatient care (2 hrs/w	k	
٠	2) What is the approximate percentage of your patient care hours in primary care? 10_%		
P	ART A – OUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
de	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question on Form R for all YES answers except for question 22. Refer to the instruction beakist for additional infinitions. You must answer ALL questions, or this form will be returned to you and your beaute removal may	consiler en	1
		YES N	٥Į
14	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15	<u>CLAIMS RESOLVED:</u> Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16	Has any lawsuit, other than a medical mainractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17	Have you been charged with any criminal offense, other than a minor traffic violation?		
18	Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, demed, restricted by, or surrendered to any state or federal agency?		1
20	Have you withdrawn an application for a medical license or been demed a medical license for any reason?	٠.	
21	Has any professional hability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22	CME CERTIFICATION: Have you completed your CMB requirements preceding your renewal date? Yes	☐ No	
	☐ CME Warver requested (CME warver form due 30 days prior to date of license experation) ☐ CMI	s exemption	
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applicat	ion.	
Pan	mant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule at	mount	
Pun Maa	suant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusotts state tax ruturus and par sachusotts state taxes that are required under law. <u>NOTE</u> . This applies even if you radide out-of-state or out of the United	i ali I Status	
	Pursuant to G.L.c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A r withholding and remitting Child Support.	elating to	
	Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 52		
•	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form ${f R}$ is	true	
Sign	ature BOLS M.D. Date 3	30,01	

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

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

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



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

# Physician Registration Renewal Application

Remit \$400.00 for renewal fee (non-refunda - Add late fee of \$25.00, if necessary.	
Please review carefully the following infor- alterations as required. <u>All auestions</u> must	mation for accuracy and completeness. Make fuy confections of be answered or your renewal will be delayed.
1. Current Status: Active Registration	on No.51701 Renewal Date:04/12/2005 8
If you want to change your current status, please check	one of the following boxes to indicate your new status. (Check only one)
Active Retiring (see instructions)	☐ Inactive (see instructions) ☐ Do not wish to renew
2. Other Name(s), if any, under which you were license	Please make corrections (print)
A) Mailing/Business Address: 3. BORIS I ORKIN	Other Name(s) Name Change (enter name below)
	Mailing Address:
	City/Town: State:
	Zip: Country:
B) Home Address:	
	Business Address: City/Town: State:
•	City/Town: State:State:
	Business Telephone: ( )
	Home Address:
<b></b>	City/Town: State:
Home Phone:	Zip: Country:
Business Phone: ((17) 277-0090	Home Telephone: ()
China Contraction	PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.
) Date of Birth: b) Sex: M	7. Current American Board of Medical Specialtsee Certification (See <u>Table 2</u> ) Code: OG Code:
Name of Medical School:	8.Drug License Numbers, if env
Ivan-Frankovskij Medical Institute	a) Federal (DEA):
Year Graduated: 1972 c) Degree: M.D.	b) Massachusetts:
17.2	9. a) Other states where you are now licensed to practice (Abbr.)
cialty Code(s) (See <u>Table 1</u> )  c(s)	b) States where you were previously licensed (Abbr.)
e. (Supply the codes from <u>Table 3</u> and place a check t	ffiliated or have completed the credentialing process for the provision of patients next to those health care facilities where you have admitting privileges (patient care hours that you provide in each facility).  No affiliations.

PR	INT YOUR LAST NAME:	ORKIN	LICENSE NUMBER	. 51+01
11.	My medical malpractice insurar	nce is covered by 🔀 Insurance	Carrier	
	Insurer's name. (Required):	<u> </u>	Policy dates: Prom://	To:
	Alternatively, indicate as follow because I am: Check One:	vs) I am registering with Active s Not involved in direct/indirect p	intus but I am not covered by medical atient care in Massachusetts A	melpractice insurance government employee.
	Otherwise exempt Please ex	plain exemption:		
12.	What is your principal work set for the provision of patient care	ting? (See Table 4) <u>75</u> <u>25</u> you must complete question #10	If you are affiliated with a healthen on page 1 and list your affiliations.	re facility or oredentialed
13,	Care of patients in Massachuset			
			hre/wk B) outputient care 40	<u>}_hen/wk</u>
	•	percentage of your patient care h		
			T TWO (2) YEARS (SEE IN	,
Qu	stions 14 through 22 refer to t	he period since you dened your	last renewal emiliación. Check elt	er YES or NO to each
	definitions. ALL questions in	title section areas be answered.	question 22). Roller to instructions. Do not amover NA or the farm will	The second section of the section of
	r renewal.			
				YES NO
14.	CLAIMS MADE (New or Penyet been finally settled or adjudi	ding): Has any medical malpract cated, whether or not a lawsuit w	ice claim been made against you that as filed in relation to the claim?	has not
15.		y medical malpractice claim that individual whether or not a lawsuit was it	has been made against you been settle Had to relation to the albino?	d,
16.	Has any lawsuit, other than a me	edical malpractice suit, which is re	elated to your competency to practice	
	or your professional conduct in otherwise resolved?	the practice of modicine, been file	d against you or been settled, adjudic	sted or
17.	Have you been charged with any	criminal offense?		•
18.			ws, rules, by-laws or standards of prac professional society or association?	rtice of
	Has your privilege to possess, di restricted by, or surrendered to a		etances been suspended, sevolved, de	wied,
20.	Have you withdrawn an applicat	ion for a medical license or been	denied a medical license for any reaso	<b>m?</b>
	co-payment, or placed any condi	ition related to professional compo d or terminated your insurance co	i, terminated, imposed a surcharge or stency or conduct on your coverage, o verage in response to an inquiry by a	r have
			irements preceding your renewal dete	2 V V- 17 No
	_		O days prior to license expiration date	
	CME EXEMPTION: Check of	'	Residency/Fellowship training (See	
		<del></del>	it documentation of your CMEs wi	th application.
	and the punishment for failu	re to comply.	to report abuse or neglect of children	
	<ul> <li>Pursuant to G.L. c. 112, Secarament.</li> </ul>	. 2, I will not charge to or collect	from a Medicare beneficiary more the	n the Medicare fee schedule
	Pursuant to G.L. c. 62C, 49/ Massaclassetts state tax return	ns and payment of all Massachus	ith all laws of the Commonwealth reli sits state taxes; reporting of employee pant to G.L. c. 119A. (See instruction	s and contractors under
Ib	ereby certify under the femalti	es of perjury that all informatic	n on this Renewal Application, Par	B and Form R is true.
sign	ature:	m.o		5/12/03
			VITH YOUR RENEWAL AP	

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

Massachuse	ns Physicia	fi Verream	Application	701	
Physician Name: BORIS   ORKIN					
Corrent Status: Active  If you want to change your curren (Check only one). (See Renewa		one of the following	Strik De ng bosse to indicate yo Do not wish t	er Will spaper.	
Active   Retir			e charges, if usessess	y. You are	
Addresses & Contact Information. F paired to notify the Board of Registr places addresses <u>CANNOT</u> be a Post	tunce editarit your attor in Middeine w Office Box.		y change of address. In conventions (print)	Home and	
2a) MAILING ADDRESS	, <b>*</b>	Mailing Addre	•		
•		Cleviews:		State:	
		de	Country:	-	<u> </u>
Check here to change this address	27.				
2b) HOME ADDRESS		Home Allen			
•	2	Challen.		Steak;	
	285 APR 25	Zlp:i_	Country:	<u></u>	
	X 23		hans:()	- Office Fore	
Phone:  [3] Check have to change this address	S. 30	Hope	nitres entret be a Po	et Office Der	
2c) BUSINESS ADDRESS		Biofeste A	Såreeg:		
1180 BEACON STREET		CityTota			TAT
SUITE 5B BROOKLINE, MA 02446	. 4	Zp	Contract	FINE	##
•		Property T			
Physic: (617)277-8090  Check have to alonge this address	,	ent ( )	NA. IIIII	4 3000	سنا "
as an area to A Administra	·	. 7.4	11   4    ""	•	_4.
9 Pax Number: (617) 2	77-4535	4		TOWN OF THE	CHE
		dett? Adju	legal markets (SC)		
5) Specialities (See Renewal Instructi					
Obstatrics and Gymecology		<del>-</del>	•		
	111		Annual de Annual de	ten (AOA) heli	
6) Curiont American Board of Mi (See enclosed instructions and Renig	dical Specialties (Al		to an interest and Suffering	والمانسي	<b>Sector</b>
List Cordlying Beard(s) below:		below. Planes a	of bounding comme	Market on Section	NOĜ.
Board Name	ABMS or AOA	Cortificate/fin	aposielly	Correct? Do	<u> </u>
ABOG	· • □	Obstatrics & O			C)
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	CONCRETE
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ce Renewal Instructions, page 4.) Drug License Rumbers, if any:	Please make Sa) Other s	correction tates who	nti az necesen Pe you aro par	y K Heeseed to 1	ractice (Abbr.)
a) Massachusetts: b) Pederal (DEA):		Apere her	we've gathelia	the Remod (	Appr.)
e) Federal (DEA) XS:	NJ				
What is your principal work setting? (See ) Principal Work Setting: Private Office Places enter the assertional number of work	k hours at your princ	ipal work	seeing 25	£30.	
i) List all current health care facilities where revision of patient care. (Supply the name o setrution bookies). Next to each facility, we used into or Consulting), and the approximate release any affiliations with on-line prescript	e you are difficied if the bealth care in rise your staff cales to number of hours ing services or cons	er have t dility fire pery at th of paties panies. Pi	completed the in Reduction T at Swilley (Ad I care that you have provide t	grederstading Judio S on Prog Judiding, Anthr a provide at S Mindormalies	nt finility. Die nädlichmet
	ntor the gapraximate	Delete?		CHARLA.	Apricalisate 6 Marie per West
Seeth Care Facility (See Renewal Instruction	u, page 4.)		Control	Change	20
Seth Israel Descouses Medical Center		.0	Admitting	<del> </del>	D
lowton-Wellesley-Hespital				-	
Triber .		<del>                                      </del>	Admitting	<del>                                     </del>	10
St. Elizabeth's Medical Ctr of Boston		H		1	
		╁ᡖ			
<u> </u>		情	1		
11) Cure of patients in Massackussite (See A Average weekly hours involved in: a) impa b) outp	Renewal Instructions stiest care	IN MP		hus/wl	
Average weekly hours involved in: a) input b) outp 12) Medical Liability Insurance Informatio My medical liability insurance is provided	nation care 40	hrs/wk ructions,	Change to:		
Average weekly hours involved in: a) input b) outp  12) Medical Linbility Insurance Informatio My medical liability insurance is provided  [5] Insurance Carrier (complete below)	nation care 40 nation care 40 na (See Reserve) Institute through: (check on	hrs/wk.	Change to:		
Average weekly hours involved in: a) input b) outp b) outp 12) Medical Linbility Insurance Informatio My medical liability insurance is provided [5] Insurance Carrier (complete below) Correct Insurance Carrier: CRIGO Policy dates: From 1.01/5	nation care 40  on (See Reserved Institute in through: (check on To 12/31	hrs/wk ructions, j	Change to:		
Average weekly hours involved in: a) input b) outp b) outp 12) Modical Liability insurance informatio My medical liability insurance is provided  [5] Insurance Carrier (complete below) Covent Insurance Carrier: CRIGO Policy dates: From 1.01/5. (required)	tient care 40 matient care 40 ma (See Renewal Institution) to 12/31 proval (attack a cap	hrs/wk rections, (e)	Change to: page 5.) Change to:	heaf of	
Average weekly hours involved in: a) input b) outp b) outp 12) Medical Linbility Insurance Informatio My medical liability insurance is provided [5] Insurance Carrier (complete below) Correct Insurance Carrier: CRIGO Policy dates: From 1.01/5	tient care  40  in (See Reserve) Institution (See Reserve) Institution (See Reserve)  To 12/31  proval (attack a captur)	hrs/wk rections, ; o) / O.5.	Change to: page 5.) Change to:	heatest	

Massachusetts Physician Renewal Application  Physician Name: BORIS FORKIN  Physician Name: BORIS FORKIN		
Bo you perform any surgery to your effice? (See Renewal Instructions, page 5.) YE Yes [] No If Yes, please complete Form PCA-O "Office Based Surgery"	ned weer last	20/26/10
If Yor, please complete Form y Colors to the following: all time from the day you signedies 14-21, the phrase "time period" refers to the following: all time from the day you sign this renewal application, inclusive. (See Resound in most renewal/application, to the day you sign this renewal application, inclusive. (See Resound in most renewal/application, to the day you sign this renewal application. If you survey "YES" to any questions to the section must be assurated.	ions. Robe to	) th
a sense check either YES or NO to each question. Provide details on <u>Porm E</u> if you served the sense he assessed.  Event instructions for additional information and definitions. ALL questions in this section must be assessed.	YES NO	3
4) CLAIMS MADE  a) New: Has any medical majoractice claim been made against you during this time period, whether or not a invent was filed on that chaim?  b) Pending: Are there any unresolved majoractice claims against you today, any claims that have not been		4
b) Pending: Are there any unresolved majoractive classes against you findly settled or finelly adjudicated?  5) CLASSES PÁED Has any medical majoractive claim against you (whether or not a lemmak was filed on that claim) been that any medical majoractive claim against you (whether or not a lemmak was filed on that claim) been		
manifest, sessed, of authorisms with the sessed ses	-	
OTHER CIVIL LAWSUITS     Question 16 refers to claims or actions related to your competency to practice medicine or your profitational conduct in the practice of medicine.  a) New: Have there been any lawsuits, other than medical melipractice claims, been filed against your a) New:		
a) New: Have there seen any invasion of the desired and the seen and the medical majorantics (auting this time period?  b) Resolved: Have you resolved, settled or adjudicated any learnable, other than medical majorantics claims, during this time period?		
17) CRIMINAL CHARGES  a) Have you been charged with any criminal offices during this time period?		
c) Have any criminal offenses/charges against you town to	•	
18) Here you been charged with or disciplined for any violation of laws, rates, system or association?  of any governmental authority, health care facility, group practice or professional society or association?	$\dashv$	
of any governmental acceptacy,  19) Has year privilegs to possess, dispense or prescribe controlled substances bean suspended, revoked, desied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical House, allowed a license application to become obsole or have you been denied a medical House for any reason?		
21) Her any medical liability insurance carrier restricted, limited, terminated, improved a mechange or co-payment, or placed any condition related to professional competency or candlest on your coverage, or terminated your insurance coverage in response to an impriry a medical liability insurance carrier?	,	
22) CME CERTIFICATION:  a) Have you completed your CME requirements preceding your renewal date?  Yes No. 19 No. 1	•	
b) If no, are you requested a Colle Walver. A CME waiver request form must be submitted at least 30 days to	nior to	
your license expiration date. (See Reserved Instructions, page 5)  o) if you are exampt from CME requirements, check remon for eccumption. (See Removal Instructions, page 5)  c) if you are exampt from CME requirements, check remon for eccumption. (See Removal Instructions, page 5)  c) if you are exampt from CME requirements, check remon for eccumption. (See Removal Instructions, page 5)  c) if you are exampt from CME requirements, check remon for eccumption. (See Removal Instructions, page 5)	,	لِـ

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There reviewed my Physician Profile at gradine.meanmediated arg and comfirm that the information is accurate.  I have reviewed my Physician Profile at gradine.meanmediated arg and comfirm that the information is accurate.  I have reviewed my Physician Profile attached a copy of the Profile with constaines.    My status is inactive and I do not have a Physician Profile. (See Remond Instructions, page 10.)    CERTIFICATIONS	, .	Massachusetts Physician Renewal Application Liume No.: 51765	•
1 have reviewed my Physician Profile at graffine measurements and the profile my Physician Profile and attached a copy of the Profile mith commitme.    1 have reviewed my Physician Profile and attached a copy of the Profile mith commitme.   1 have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the purchases for failure to comply.  2) I certify that I have compiled with my obligations to report abuse of neglect of disabled pursuant pursuant to G.L. c. 19C, sec. 10, and I understand the purchases for failure to comply.  3) I certify that I have compiled with my obligations to report abuse of neglect of disabled pursuant pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.  4) I certify that I have compiled with my obligations to report the treatment of wounds, buses and other injuries pursuant to G.L. c. 112, sec. 12A.  5) I certify that I have compiled with my obligations to report the treatment of victime of rape or semmi assemb pursuant to G.L. c. 112, sec. 12A 1/2.  6) I certify that I have compiled with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5; when I have a reasonable basis to believe that pursuant my obligations under G.L. c. 112, sec. 5 or any Board regulation.  7) I certify that I have compiled with my obligations to file Messachusetts pursuant to G.L. c. 112, sec. 5 or any Board are reasonable to G.L. c. 114, not 5 or any Board or reasonable to the Medicine file schedules and to pay Messachusetts tense, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my House shall not be issued or reasonable to child support pursuant to G.L. c. 124. c. 119A.	4		0
I have reviewed my Physician Profile and attached a copy of the Profile minimum.    My status is Inactive and I do not have a Physician Profile. (See Remonal Instructions, page 10.)    CERTIFICATIONS			Ŝ
	1	I have reviewed my Physician Profile at profiles manufactures and	Ž
CERTIFICATIONS  1) I certify that I have compiled 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 compiled with my obligations to report abuse of neglect of disabled pursuant pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.  3) I certify that I have compiled with my obligations to report abuse, neglect or financial exploitation of aborty pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to compily.  4) I certify that I have compiled with my obligations to report the treatment of wounds, beams and other injuries pursuant to G.L. c. 112, sec. 12A.  5) I certify that I have compiled with my obligations to report the treatment of victims of rape or certail assent pursuant to G.L. c. 112, sec. 12A I/2.  6) I certify that I have compiled with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 12A I/2.  7) I certify that I have a reasonable basis to believe that pursua violated my provisions of G.L. c. 112, sec. 5 or any Board regulation.  7) I certify that I have compiled my obligations related to charging and collecting from from Medicine binasticaries in accordance with the Medicine for schedule, and I understand my obligations under G.L. c. 112, sec. 2.  2) I certify that I have compiled with my obligations to file Messachusetts tax returns and to pay Messachusetts taxes, and I understand that, pursuant to G.L. c. G.C., sec. 49A, my license shall not be issued or reasonal unless I make those certifications under paralleles of payiny.  9) I certify that I have compiled with my obligations related to the supering of amployees and contractors pursuant to G.L. c. G.C., sec. 149A. my license shall not be issued or removed unless I make those certifications under paralleles of payiny.	רם יוני	tour Disminist Profile and attached a copy of the Profile with community	
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- A - A - A - A - A - A - A - A - A - A		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  11) I certify that I have complied with my obligations to file an Incident Report with the Board when the Patient Care occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3,00 et seq., and I understand that the Patient Care occur in my private office, pursuant to the health care facilities where I prestice report certain Major Incidents to the Board.	
		11) I certify that I have comprised to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 5 and 243 C.)4.R. 3:00 et seq., sec. 1 noty private office, pursuant to G.L. c. 112 sec. 1 noty private office of the Board.	

Under penalties of perjury, I declare that I have examined this renewal applicate accompanying instructions, forms and statements, and to the best of my knowle information contained herein is true, correct, and complete. I matherine the Board of Re Modicine to access any and all criminal case information on me half by the Ma

Criminal History Systems Bolard.

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

Page 5 of 5

Massachuset Physician Name: Boris I Orkin, M.D.		1 Renewal Application License No.: 51791
Check only one: (See Renewal In:  No. Active   Retiring	structions, page 3.)	: 05/15/2007 Birth Date:  """ the following boxes to indicate your <u>new</u> status:  Ctive Do not wish to renew
Addresses & Contact Information, Plea required to notify the Board of Registratic Business addresses <u>CANNOT</u> be a Post Of 2a) MAILING ADDRESS	on in Medicine within	resses and make changes, if necessary. You are in 30 days of any change of address. Home and Please make corrections (print)
	1	Mailing Address:  City/Town:  Country:
Check here to change this address  2b) HOME ADDRESS	ECEIVED	Blome Address:  Ofty/Town: State:
APR	-2 2007	Zip: Country: State: St
2c) BUSINESS ADDRESS 1180 Beacon Street Suite 5b Board of	1 3 2007 Registration	Home address cannot be a Post Office Box  Business Address:  Gity/Town:  State:  2 p:Country:
Phone: (617)277-0090  Check here to change this address	_	Business address cannot be a Past Office Box Correct your E-mail and Fax Number below:
3) E-mail Address: 4) Fax Number: 617-277-4535		
5) Specialties (See Renewal Instructions, pag Obstetrics and Gynecology	ge 4.) Delete?	List Additional Specialties:
6) Current American Board of Medical Sp (See enclosed instructions and Renewal Instru	ecialties (ABMS) or Auctions, page 4.)	American Osteopathic Association (AOA) Information.
List Certifying Board(s) below:  Board Name ABMS or AOA	Delow. Please add a	edificates and Subspecialty Certificates additional Certifications as required.
Obstetrics & Gynecology ABMS	Obstetrics and Gynec	
		0

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### Massachusetts Physician Renewal Application

Physician Name: Boris I Orkin, M.D. License No.: 51701 PART A Renewal Due Date: 05/15/2007 1) Current Status: Active 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.) ☐ 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 Mailing Address: City/Town: \_\_\_\_ Zip: Country: ☐ Check here to change this address **2b) HOME ADDRESS** Home Address: \_\_\_\_\_State: City/Town:\_\_\_ Country: Home Telephone: (\_\_\_\_) Phone: Home address cannot be a Post Office Box ☐ Check here to change this address 2c) BUSINESS ADDRESS Business Address: 1180 Beacon Street City/Town: Suite 5b Country: Brookline, MA 02446 Business Telephone: (\_\_\_)\_\_ Phone: (617)277-0090 Business address cannot be a Post Office Box ☐ Check here to change this address Correct your E-mail and Fax Number below: 3) E-mail Address: 617-277-4535 4) Fax Number: 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.) Update General Certificates and Subspecialty Certificates List Certifying Board(s) below: below. Please add additional Certifications as required. Certificate/Subspecialty Board Name **ABMS or AOA ABMS** Obstetrics and Gynecology Obstetrics & Gynecology 

# D47 17707

License No.: 51701

## Massachusetts Physician Renewal Application

Physician Name: Boris I Orkin, M.D.

(See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers Corrections: 8) Other states where you are now licensed to practice a) Massachusetts: b) Federal (DEA): ... 9) States where you were <u>previously</u> 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 bookiet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary. Location List the names of all work sites in Massachusetts State Delete? (See above and description on page 4.) (City or Town) Beth Israel Deaconess Medical Center Newton-Wellesley Hospital Ø St. Elizabeth's Medical Ctr of Boston 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 20\_ hrs/wk Average weekly hours involved in: a) inpatient care Change to: \_ hrs/wk 40 hrs/wk hrs/wk b) outpatient care Change to: 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: CRICO Change to: Policy dates: From 0 /01/2007 Claims made with tail coverage ☐ Occurrence Policy Type of 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 Rability 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.

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### Massachusetts Physician Renewal Application

Physician Name: Boris I Orkin, M.D.

License No.: 51701

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

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

net S

	YES	NO
<ul> <li>14) CLAIMS MADE</li> <li>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).</li> <li>b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?</li> </ul>		
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.		
<ul> <li>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?</li> <li>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</li> </ul>		
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?		
<ul> <li>d) Are any Applications for Issuance of Process pending against you?</li> <li>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS <ul> <li>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</li> <li>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?</li> <li>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?</li> <li>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?</li> </ul> </li> </ul>		
<ul> <li>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?</li> <li>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?</li> </ul>		
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?  b) If no, are you requesting a CME waiver?  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

CME EXEMPTION: (check one)

Physician Name: Boris I Orkin, M.D. License No.: 51701

#### PART C

PHYSICIAN PROFILE Check One: 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.

#### **CERTIFICATIONS**

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

- 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 sec. 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:

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.

Page 5 of 9

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Physician Name: Boris I Orkin, M.D. License No.: 51701 NATIONAL PROVIDER IDENTIFIER (NP) 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. Ontion 5: If your license status is INACTIVE, you may elect not to obtain an NPI number. Check the appropriate box below, supply appropriate information, and sign the bottom of the page. **1140** | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 | 140 ☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.) ☐ I have applied for an NPI using a third party (enter name): — (follow instructions for Option 3) By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf. As an inactive physician, I do not wish to obtain an NPI. **HIPAA TAXONOMY CODES** Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf, Taxonomy (Specialty) Code Taxonomy Description (Print) OBSTETRICS EGYNECOLOGY-HYNELdo Primary Provider Taxonomy: Provider Taxonomy: Provider Taxonomy: 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): ☐ Female Penalties for Falsifving 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 number to any authorized hospital, health plan, or health organization. Please sign and date to confirm that all of the information on this form is true and accurate.

\_\_\_\_\_Date: 3 /28/07

Signature:

Physician Name: Boris I Orkin, M.D. License No.: 51701 PART A 1) Current Status: Active Renewal Due Date: 05/15/2009 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.) ☐ Retiring Active ☐ Inactive Do not with to renew 2) Addresses & Contact Information. Piease 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 <u>CANNOT</u> be a Post Office Box. Please make corrections (print) 2a) MAILING ADDRESS Mailing Address: \_\_\_\_\_ State: City/Town: \_\_\_ Zip: Country: ☐ Check here to change this address **2b) HOME ADDRESS** Home Address: City/Town: State: Country: Zip: Home Telephone: (\_\_\_) APR 22 2009 Phone: Home address cannot be a Post Office Box Check here to change this address Board of Registration 2c) BUŞINESS ADDRESS Business Address: in Medicine 1180 Beacon Street City/Town: State: Suite 5b Brookline, MA 02446 Zip: Country: Business Telephone: (\_\_\_) Phone: (617)277-0090 Business address cannot be a Post Office Box ☐ Check here to change this address Correct your E-mail and Fax Number below; 3) E-mail Address: 4) Fax Number: 617-277-4535 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.

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				. 0
				•	•	. 0
		·				D
	_					. 0

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### Massachusetts Physician Renewal Application

License No.: 51701

Physician Name: Boris I Orkin, M.D.

(See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers Corrections: 8) Other states where you are <u>now</u> licensed to practice a) Massachusetts: b) Federal (DEA): 9) States where you were previously licensed c) Federal (DEA) XS: 10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate shoot, if necessary. List the names of all work sites in Massachusetts Location State Delete? (See above and description on page 4.) (City or Town) Beth Israel Deaconess Medical Center BOSTON Newton-Wellesley Hospital 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 20 hrs/wk Average weekly hours involved in: a) impatient care Change to: \_\_ \_ brs/wk 40 hra/wk b) outpatient care Change to: bre/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: CRICO Change to: . From 1/1/9009 To 12/31/2009 Policy dates: Occurrence Policy Claims made with tail coverage Type of 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: Not involved with direct or indirect patient care in Massachusetts Check one: 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.



CONTROLLED RISK INSURANCE COMPANY OF VERMONT INC. (A Blak Retention Group) Bustington, Vermont

#### Confirmation of Physicians, Dentists, and Podiatrists Professional Liability Insurance

BETH ISRAEL DEACONESS MEDICAL CENTER, INC.

Date: 04/20/2009

BORIS I, ORKIN MD BETH ISRAEL DEACONESS MEDICAL CENTER, INC. 330 BROOKLINE AVE BOSTON, MA 02215

This confirms the existence of your insurance coverage as set forth below. Coverage is subject to all the terms, conditions and exclusions of the policy referenced below.

No person, organization or entity who is insured for liability for injury arising from a "Medical Incident" under any other policy of insurance issued by the "Company" shall be insured under the policy of insurance reflecenced below. No person, organization or entity is entitled to more than a single each claim or annual aggregate limit of liability during the "Policy Period" reflecenced below, segardless of the number of different especials in which such person, organization or entity might qualify as an "Insured".

Prohesional Linbility:

Limits of Liability:

\$5,000,000,00

cach "Claim"

\$10,000,000.00

annual aggregate, for all claims made during the "Policy Period"

**Policy Number:** 

BIDMC-CRICO-C-GLPL-1152-2009

**Policy Period:** 

01/01/2009 - 12/31/2009

All the turns, conditions and exclusions, including the limits of liability may be subject to change effective 01/01/2010.

Coverage terminetes as respects physicians, dentists, and podiatrists at the earlier of:

- a) The date upon which the individual elects to cancel coverage; or
- b) The date the individual is removed from the Schedule of Insured Physicians, Dentists, and Podiatriets maintained by the Rick Management Foundation.

Terms appearing in quotation marks in this Confirmation shall have the same meaning as the definition of that term in the policy.

Any request for claim information should be directed to Risk Management Foundation, 101 Main Street, Cambridge, Massachusotts, 02142, agent of the Named Insured.

Controlled Rick Insurance Company of Verment, Inc.

alien & Jones

Alison B Jones
Duly Authorized Representative

# 04/23/09 \$1

### Massachusetts Physician Renewal Application

Physician Name: Boris I Orkin, M.D.

License No.: 51701

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	1
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?	· . <u>.</u>
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?	
29) 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	٠
b) If no, are you requesting a CME waiver?	

☐ Inactive Status

☐ Residency/Fellowship training

CME EXEMPTION: (check one)

Physician Name: Boris I Orkin, M.D. License No.: 51701

#### PART C

#### **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 seg. 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.

#### Check One:

#### PHYSICIAN PROFILE

M'	I have reviewed my Physician Profile at <a href="http://profiles.massmedboard.org">http://profiles.massmedboard.org</a> 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.)	

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: Date: 41

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.

04/23/08 S1



Physician Name: Boris i Orkin, M.D. License No.	.: 5	1701
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**Current Status:** Active

License Expiration Date: 6/12/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

**Business Address:** 

1180 Beacon Street

Suite 5b

**Brookline** 

Massachusetts - 02446 United States of America

(617) 277-0090

3) Email Address:

4) Fax Number: (617) 277-4535

5) Specialties

Obstetrics and Gynecology

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

Information

ABMS/AOA **Board Name** 

**ABMS** 

Obstetrics & Gynecology

Certification

Subspecialty

Obstetrics and Gynecology

7) Drug License Numbers

**Massachusetts** 

Federal (DEA)

Federal (DEA) XS

- 8) Other states where you are now licensed to practice None Reported
- 9) States where you were previously licensed New Jersey

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

**WorkSite** 

Location

Beth Israel Deaconess Medical Center

Page 1 of 5 Date: 4/19/2011 Time: 1:21 PM



Physician Name: Boris I Orkin, M.D.

License No.: 51701

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 20 hrs/wk

b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

**Insurance Carrier** 

**Policy Start Date** 

**Policy End Date** 

**Policy Type** 

**CRICO** 

01/01/2011

12/31/2011

Occurrence Policy

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

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?

b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

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

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?

b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

a) Have you been charged with any criminal offense during this period?

b) Have any criminal offenses/charges against you been resolved during this time period?

c) Are there any criminal charges pending against you today?

d) Are any Application of Issuance of Process pending against you?

18) Other Issues

a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?

b) Have you ever taken a leave of absence from any health care facility, group practice or employer?

- c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
- d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?
- 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?
- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Page 2 of 5 Date: 4/19/2011 Time: 1:21 PM



Physician Name: Boris I Orkin, M.D.

License No.: 51701

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)

Page 3 of 5 Date: 4/19/2011 Time: 1:21 PM



Physician Name: Boris I Orkin, M.D.

License No.: 51701

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?

Page 4 of 5

Date: 4/19/2011

Time: 1:21 PM



Physician Name: Boris I Orkin, M.D.

License No.: 51701

#### Compliance with Legal Responsibilities

Online profile:

IXI have reviewed my Physician Profile and confirm that the information is accurate.

- I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) 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, certify that the information contained herein is true, accurate, and complete.

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