Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
. (617)727-2398
Fax: (617) 451-6568
An Agency within the Office of Consumer Affairs and Business Regulation

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR
PENELOPE WELLS
GENERAL COUNSEL

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April 24, 1997

Boris I. Orkin, M.D.

Re: Complaint No. 97-053

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.**
*Obstetrics and Gynecology*
1180 Beacon Street, Suite 6B
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 Hasting House for pregnancy termination. She was referred by MGH where she was a patient for some time. Her past medical history is significant for vestibulitis-disease that can cause significant pain in the vulva. underwent numerous vulvovaginal surgeries to alleviate her pains and subsequently was taking Zoloft to relief her symptoms. She also has a history of pelvic and vaginal infections, including herpes genitalis. developed hepatitis secondary to anesthesia.

Crittenton Hasting House is facility that provides different services including pregnancy termination. Upon arrival patients stay on the first floor where they complete different forms and undergo extensive counseling. This process takes some time until all the patient's questions and concerns are resolved. After this process is completed the patient is taken to the third floor by a medical assistant. The medical assistant brings 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 exam is performed with lubricated gloves in order to make it more comfortable and to alleviate discomfort from speculum insertion. Knowing history, all was done very carefully along with paracervical anesthesia for which she received 20 cc of 1% xylocaine. Her cervical canal was dilated after that. Suction was done. It is routine procedure to withdraw and reinsert suction in order to assure that all tissue is removed. A sharp curette was not used during Ms. procedure. There were no complications of procedure as well as no that recorded that she passed out or vomited, although local injections of xylocaine can cause unusual sensations in the mouth and the patient can become light headed. The physician then leaves the room after being assured that patient is 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 assure completeness of the procedure. Instruments and tissues are covered before taking them out of the room.

There is a bathroom on the third floor which has three separate cabins with locks 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 after each session.

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 Crittenton Hasting House territory between the Board investigator and myself in order to clarify any issue.

Respectfully, Boris Orkin, M.D. B Orkin, M.D

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111
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EXECUTIVE DIRECTOR
PENELOPE WELLS, J.D.
GENERAL COUNSEL

# COMPLAINT FORM

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

| ☐ Mrs. ☐ Ms ☐ Mr. Your First Name | Last Name | Patient Name (if different) |
|---|---|---|
| Street Address | | Mailing Address (if different) |
| City | State | Zip Code |
| Business/Daytime Phone | | Home Phone |

Complaint against M.D. X, D.O. ____, Acupuncturist ____. **(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-3076, or 100 Cambridge St., Boston, MA 02202.)**

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

| Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable. | | |
|---|---|---|
| BORIS ORKIN | | |
| Address: Ten Perthshire Rd | | |
| City: Boston | State: MA | Zip Code: 02135 |
| Business Phone: 617 782 7600 | | |
| Name and Location of Health Care Facility (if known): CRITTENTON HOUSE / BRIGHTON, MA | | |

**Nature of Complaint**

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

Please do not write below this line.

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

## Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address:-

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

Signature of Patient (Or Legal Representative) _____ Date: 1/18/97

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

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

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

HUNT HOSPITAL / DANVERS, MA

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

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

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

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

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

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

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

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

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

Dates of Treatment: ___ ____ 1997

09/08/98 S1 154

## ADDENDUM TO COMPLAINT FORM

1) Referred by MGH to Crittenton for pregnancy termination, as fetus was not viable per MGH recommendation. MGH assured me I would be given anesthesia or a sedative for pain management.
2) 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 Crittenton, 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 Orkin located nurse to assist.
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 lining 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

X B. Orkin
APPLICANT'S SIGNATURE

**SEE REVERSE SIDE** C KC

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, YOU MUST CHECK THIS BOX: ☐

REDACTED COPY

PLEASE USE THE ENCLOSED RETURN ENVELOPE

| LICENSE NUMBER | | | PAY THIS AMOUNT | FEE | DATE TO BE RENEWED | | | LATE FEE |
|---|---|---|---|---|---|---|---|---|
| CODE | TYPE | REGISTRATION NO | | | MO | DA | YR | |
| MD | | 51701 | 100.00 | 100.00 | 01 | 15 | 86 | |

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

BORIS I ORKIN

DO NOT FOLD OR STAPLE THIS FORM

DO NOT WRITE BELOW THIS LINE

**NOTE!** 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: Ivano-Frankovsk USSR Date of Graduation: 1972

You must read the instructions enclosed with this form to answer questions 1-12.

1. Principal Specialty(ies): OB/GYN

2. Principal work setting: RESIDENT, OB/GYN

3. Home address: 867 [illegible]

4. Principal business address: St. Elizabeth's Hosp. 736 Cambridge St.

5. List all hospitals at which you have currently effective privileges: St. Elizabeth's Hosp. Boston, MA 02135

6. States other than Massachusetts in which you are licensed to practice: —

| | YES | NO |
|---|---|---|
| 7. Have you been a defendant in any malpractice suit commenced since 10/1/83? | | |
| 8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83? | | |
| 9. Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? | | |

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: 100 hours CAT. I.

12. I am an active . ✓ . inactive ___ . practitioner. (Check one)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE. B. Orkin

SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

**BOARD OF REGISTRATION IN MEDICINE**
TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC. NUMBER, OPTIONAL

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☐
PLEASE USE THE ENCLOSED RETURN ENVELOPE

| LICENSE NUMBER | | | PAY THIS AMOUNT | FEE | DATE TO BE RENEWED | | | LATE FEE |
|---|---|---|---|---|---|---|---|---|
| CODE | TYPE | REGISTRATION NO. | | | MO | DA | YR | |
| MD | 1 | 51701 | $100 | 100 | 06 | 12 | 87 | |

**NOTE!** 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
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

BORIS I ORKIN

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: BORIS I. ORKIN 2. Date of Birth: ____ (MONTH) ____ (DAY) ____ (YEAR)
3. Medical School: IVANO-FRANKOVSKI, USSR M.D.? ☒ D.O.? ☐ (Check One.)
4. Country where Medical School located: USSR 5. Date of Graduation: JUNE 1992
6. American Specialty Board Certified? ☐ (Check if yes.)
Which Boards? ____
7. Principal Specialty(ies): OB/GYN 8. Principal work setting: RESIDENT
9. Home address: ____ 10. Principal business address: St. ELIZABETH'S HOSP 736 CAMBRIDGE ST. BOSTON, 02135
11. List all hospitals at which you have currently effective privileges: ST. ELIZABETH'S HOSP. OF BOSTON
12. List all hospitals at which you have held privileges in the past 20 years: WALTHAM HOSP, MA; MOSCOW CITY TEACH HOSP
13. States other than Massachusetts in which you are presently licensed to practice: —
14. List any other states where you were previously licensed to practice: —

| | YES | NO |
|---|---|---|
| 15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time? | | |
| 19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason? | | |
| 20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever, for any reason, lost American Specialty Board Certification? | | |
| 24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)? | | |

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: CURRENTLY OB/GYN RESIDENT PGY-2
26. I am an active ☒ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.
PURSUANT TO CHAPTER 475 OF THE ACTS OF 1986, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.
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. PLEASE NOTE: THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

Boris Orkin MD
SIGNATURE

DATE: April 4, 1987

(See Reverse Side)

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1988-1991 Physician Registration Renewal Application, Page 1 of 2

033964

Board Use Only:

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 51701 | 1 | $150 | 6/12/89 |

Boris I Orkin

RECEIVED MAR 30 1989

M.R. Pr. Bk. Ch. D.E. R.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--it is not acceptable to state that the Board already has the information.*
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST): ORKIN (FIRST): BORIS (M.I.:)

1. b) Other Name(s), if any, that you were ever licensed under: —

2. a) Address (Mailing):

2. b) Address (Home):

2. c) Address (Business): UMDNJ, Dept. OB/GYN
150 BERGEN ST, NEWARK, NJ 07103

2. d) Telephone (Business): (201) 456-6000 Extension 735 2. e) Telephone (Home) (Optional): (

3. Date of Birth (MO/DA/YR): 4. Sex: MALE ✓ FEMALE 5. Social Security No. (Optional):

6. a) Medical School Code (*See Table 1*): RUS30 If 99999, write Name:

6. b) Year Graduated: 72 6. c) Degree: M.D. ✓ D.O.

6. d) Country: U.S. Canada Code if Other (*See Table 2*): 173 If 999, write Name:

7. Work Setting (*Circle and Indicate Percent(%) of Practice Time*):

| | | | | | |
|---|---|---|---|---|---|
| 10 Hospital | 100 % | 15 Private Office | % | 20 Partnership/Group Practice | % |
| 25 Clinic | % | 30 Mental Health Center | % | 35 Nursing Home | % |
| 40 HMO Facility | % | 45 Educational Institution | % | 50 Medical Society | % |
| 55 Government Facility | % | 60 Plant/Commercial Setting | % | 99 Other | % |

8. Professional Activity (*Circle and Indicate Percent(%) of Professional Time*):

| | | | | |
|---|---|---|---|---|
| 10 Resident or Fellow | 100 % | 20 Practice Involving Direct Patient Care | % | 8. b) Mass. Lic. Issue Date (*see your wall certificate*) (MO/DA/YR): 10/14/83 |
| 30 Administrative Activities | % | 40 Medical Teaching | % | |
| 50 Medical Research | % | 99 Other | % | |

9. Specialty Code (*See Table 3*): OB6 Percent of Practice Time: 100 % Specialty Code: Percent of Practice Time: %
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) N 10. b) If YES, circle which Board(s):

| | | | | | |
|---|---|---|---|---|---|
| AI | Board of Allergy & Immunology | NM | Board of Nuclear Medicine | PS | Board of Plastic Surgery |
| A | Board of Anesthesiology | OG | Board of Obstetrics & Gynecology | PM | Board of Preventive Medicine |
| CRS | Board of Colon & Rectal Surgery | OP | Board of Ophthalmology | PN | Board of Psychiatry & Neurology |
| D | Board of Dermatology | OS | Board of Orthopedic Surgery | R | Board of Radiology |
| EM | Board of Emergency Medicine | OT | Board of Otolaryngology | S | Board of Surgery |
| FP | Board of Family Practice | PA | Board of Pathology | TS | Board of Thoracic Surgery |
| IM | Board of Internal Medicine | PE | Board of Pediatrics | U | Board of Urology |
| NS | Board of Neurological Surgery | PMR | Board of Physical Medicine & Rehabilitation | | |

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. (*See Table 4.*)

| | | |
|---|---|---|
| Facility Code: % | Facility Code: % | Facility Code: % |
| Facility Code: % | Facility Code: % | Facility Code: % |

If 999, write Name(s): UMDNJ, NEWARK, NJ

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. (*See Table 4.*)

Facility Code: 085 Facility Code: 067 Facility Code: Facility Code: Facility Code:

If 999, write Name(s):

I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.

Pursuant to M.G.L. c.47S, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. Note: This applies even if you reside out-of-state or out of the country.

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) attached pages--is true.

Signature: B. Orkin, M.D. Date: 3/28/89

## Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

*Fill in name and number.* Physician Last Name: ORKIN Registration No.: 51701

12. a) Other States where you are now licensed to practice (Abbreviate): NJ

12. b) States where you previously were licensed to practice (Abbreviate):

13. I am applying to be registered with the following status: ACTIVE V INACTIVE *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

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 type of residency, or check waiver.)*
Category I: ____ hrs., Category II: ____ hrs., (Risk-Management: ____ hrs.); Residency Program in: UMDNJ, OB/GYN;
Waiver Requested ___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ___ LETTER OF CREDIT V. *If applicable, check one and identify the name.*
Insurer: ____ Institution issuing Letter of Credit: UMDNJ
*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* WILL START PRACTICE IN MASS. July 1, 89

14. c) Percent of Practice Time in Massachusetts: 100 %,

*Questions 15 through 17 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details on Form 18A, attached.* Yes No

15. Has 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*?.....

17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations–See *Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? .....

**If you answered "YES" to question 15, 16, or 17 provide details on Form 18A, attached.**

*Questions 18 through 24 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details in the next section.* Yes No

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? .....

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?.....

23. Have you, for any reason, lost American Specialty Board Certification?.....

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* _____ _____ _____ .....

# Commonwealth of Massachusetts Board of Registration in Medicine
## Ten West Street, 3rd Floor, Boston, Massachusetts 02111
## 1991-1993 Physician Registration Renewal Application

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 51701 | ACTIVE | $150 | 06/12/91 |

Dr. BORIS I ORKIN

**For Office Use Only**
M.R. ____ / / ____
Pr. / / ____
Bk. APR 17 1991 / / ____
Ob. / / ____
D.E. [illegible] 4/30/91

**Directions:**
- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

**Activity Status:**
I am applying to be registered with the following status: Active V Inactive ____
I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

**Pre-Printed Information** [redacted]

**Corrections of Pre-Printed Information**

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

Name: ____

2. a) Address (Home): $

Address: ____
City/Town ____
State: ____ Zip: ____
Country Code: ____ (If 999 write Country): ____

2. b) Address (Business):
493 WESTERN AVENUE
[illegible]RISON BUILDING, 4TH FL.
LYNN, MA 01904-

Address: ____
City/Town: ____
State: ____ Zip: ____
Country Code: ____ (If 999, write Country): ____

3. Date of Birth: Sex: M
Lic. Issue Date: 10/14/63 SSN #:
Telephone Number:
Home Business
(201)456-6000

Date of Birth (M/D/Y): ____/____/____ Sex (M/F): ____
Lic. Issue Date(M/D/Y): ____/____/____ SSN #: ____
Home: ____ Business: (617) 592-3000

4. Medical School Code: RUS30 Year Graduated: 72 Degree: MD
Name of School:
Ivan-Frankovskij Medical Institute

School Code: ____ Year Graduated: ____ Degree (MD/DO): ____
If 99999, write School: ____

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

6. Specialty Code(s) *(See Table 3)*:

| Code | Hours per Week in Mass. | |
|---|---|---|
| OBG | 8 0 | Obstetrics and Gynecology |

| Code | Hours per Week in Mass. |
|---|---|
| ____ | 50-60 |
| ____ | ____ |

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) N 7.b) If YES, Enter Codes:
Code:
Code:

Code: ____
Code: ____

8. Drug License Number(s) (If any) [optional]: a) Federal (DEA) ____ b) How many DEA nos. do you have? ____
c) State (MA) #M ____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES V Waiver Requested ____
(You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*



[For Office Use Only: Waiver Granted ____ Date: ____/____/____]

FILL IN NAME AND NUMBER:

Physician Last Name: ORKIN Registration No.: 51701

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT _____. If applicable, check one.

List Insurer: TIIA

*Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one):*

(I) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: _____ (II) OTHERWISE EXEMPT: _____

*(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 / ✓ (AP) Facility Code: ____ / ____ (AP) Facility Code: ____ / ____ (AP)

*If 999, write Name(s):* _____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code: ____ Facility Code: 85 Facility Code: ____ Facility Code: ____

*If 999, write Name(s):* _____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes ____ No ✓ (Check one.)

b) *If you are in a MA program, are you a* I) Resident ____ II) Clinical Fellow ____ *or* III) Research Fellow ____? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program? _____ hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 50-60 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 40 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 2 0

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 18A. Refer to the instruction booklet for additional information.

| | Yes | No |
|---|---|---|
| 15. Has *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? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you *now*, or have you been *in the past four years*, dependent upon alcohol or drugs? | | |

**Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.**

**Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.**

**I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.**

**I hereby certify under the penalties of perjury that all information on this form and Form 18A is true.**

Signature: BOrkin, M.D. Date 4, 10, 91

# Commonwealth of Massachusetts Board of Registration in Medicine
## Ten West Street, 3rd Floor, Boston, Massachusetts 02111
## 1993-1995 Physician Registration Renewal Application

#15

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| 51701 | ACTIVE | $250.00 | 06/12/93 | $25.00 |

**Mailing Address:**
BORIS I ORKIN, M.D.

**Correction of Mailing Address:**
Address (Mailing): _____
City/Town: _____
State: _____
Country Code (See Table 1) _____

**Directions:** Staple check to bottom of form. Add late fee if necessary.
- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.
- Before proceeding, please read the instruction booklet. Some questions are optional.
- Make a copy of this form and all attachments for your own records - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
MR. APR 13 1993
#: 26
Init:

**Pre-Printed Information**

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

2. a) Address (Home):

   b) Address (Business).
   493 WESTERN AVENUE
   IRISON BUILDING, 4TH FL.
   LYNN, MA 01904

3. Date of Birth: Sex: M
   Lic Issue Date. 10/14/83 SS#
   Telephone Number
   Home: Business: (617)592-3000

4. Name of Medical School
   Ivan-Frankovskij Medical Institute
   Year Graduated 72 Degree: MD

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

6. Specialty Code(s) (See Table 2)

| Code | Hours per Week in Mass |
|---|---|
| OBG | 60 |
| 0 | |

   Obstetrics and Gynecology

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code

8. Drug License Number(s), if any a) Federal (DEA)
   b) State (MA)

**Corrections of Pre-Printed Information**

Name. _____
Address (Home): _____
City/Town _____
State: _____ Zip _____
Country Code. _____ If 999 print Country: _____
Address (Business). 1180 BEACON ST. SUITE 5B
City/Town: BROOKLINE MA 02146
Country Code. _____ If 999 print Country. _____

Date of Birth (M/D/Y). / / Sex (M/F): _____
Lic. Issue Date (M/D/Y) / / SS# _____
Telephone Number:
Home ( ) _____ Business (617) 277-0090

Full Name of Medical School. _____

Year Graduated: _____ Degree (MD/DO). _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

| Code | Hours per Week in Mass |
|---|---|
| ___ ___ ___ | _____ |
| ___ ___ ___ | _____ |

If OS, print specialty _____

Code _____ Code _____

Code. _____ Code. _____

Federal (DEA): _____
State (MA) _____

9 I have completed my CME requirements in the two years preceding my renewal date: Yes Y No, waiver requested _____
You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

**Staple Check Here**

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

11 My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT ___ If applicable, check one.

List Insurer: JUA OF MASS.

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

(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS: ___ (ii) OTHERWISE EXEMPT: ___

(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 8 5 ___ / ✓ (AP) Facility Code ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: 1 4 ___ / ✓ (AP) Facility Code ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: 8 ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): ___

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

14 a) What is your principal work setting? (See Table 5) 1 5

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

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

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

Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

| IN THE PAST TWO YEARS: | YES | NO |
|---|---|---|
| 15 Has any medical malpractice claim been made against you, whether or not a lawsuit was filed 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, revoked, denied or restricted by any state or federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had an organic illness which has impaired your ability 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 surcharge on your coverage? | | |

• Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.

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

• I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.

• I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.

Signature: BOrkin, M.D. Date: 4,8,93

# 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 | Renewal Date | Late Fee |
|---|---|---|---|---|
| 51701 | ACTIVE | $250.00 | 06/12/95 | $25.00 |

Mailing Address:
BORIS I ORKIN, M.D.

**Correction of Mailing Address**

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

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

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

[redacted]

BOARD OF REGISTRATION
IN MEDICINE

**Pre-Printed Information**

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

2. Business Address:
1180 BEACON ST.SUITE 5B
BROOKLINE, MA 02146

3. Date of Birth: Sex: M
Lic. Issue Date: 10/14/83 SS#:

Home Phone Business Phone
(617)277-0090

4. Name of Medical School:
Ivan-Frankovskij Medical Institute

Year Graduated: 72 Degree: MD

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

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

| Code | Hours per Week in Mass. |
|---|---|
| OBG | 60 |

Obstetrics and Gynecology

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

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

**Corrections of Pre-Printed Information**

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

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

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____

Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code _____ Hours per Week in Mass. _____
_____ _____
If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: _____ Registration Number: _____

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

Facility Code: 85 / ✓ (AP) Facility Code: 75 / ✓ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 48 / ✓ (AP) Facility Code: 14 / ✓ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

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

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

If 999, write name(s): _____

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

List Insurer: MMPIA

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

State how otherwise exempt: _____

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

13. a) What is your principal work setting? (See Table 4) ___

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 hrs/wk

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

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 20 %

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

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

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

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

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

Signature: B Olsen, M.D. Date: 4/4/95

# Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

# Physician Registration Renewal Application

*1H

**Before proceeding, please read the instruction booklet.**

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

RECEIVED APR 24 997

Registration No 51701 Renewal Date: 06/12/97

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

MAY 17 997

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

3 A) Mailing/Home Address

[redacted] M.D.

B) Business Address:
1180 BEACON ST STE 5B
BROOKLINE, MA 02146-3806

Home Phone.
Business Phone (617)277-0090

4 A) Date of Birth C) Sex M
B) Lic Issue Date 10/14/83 D) SS#

5 A) Name of Medical School
Ivan-Frankovskij Medical Institute

B) Year Graduated 72 C) Degree MD

6 Specialty Code(s) (See Table 1)

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

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

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

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

**Corrections (type or print)**

Other Name(s):

Mailing Address
City/Town State
Zip Country

Other Address
City/Town State
Zip Country:

Home ( )
Business ( )

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

Full Name of Medical School

Year Graduated Degree (MD/DO)

| Code(s) | Hours Per Week in Mass |
|---|---|
| | |
| | |

If OS, Print Specialty.

Code Code

Federal (DEA)
Mass

Abbr
Abbr

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

PRINT NAME AND NUMBER: Last Name: ORKIN Registration Number: 51701

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

Facility Code: 691 (AP) Facility Code: 751 (AP) Facility Code: 141 (AP)
Facility Code: 491 (AP) Facility Code: 851 (AP) Facility Code: ___/ (AP)
If 999, print name(s): _____

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

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

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ___ b) Letter of Credit
Name of Insurer: PIAM / CRICO (last year)

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because
I am (check one) a)___ Not involved in direct/indirect patient care in Massachusetts b)___ Otherwise exempt
Please explain exemption: _____

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

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

B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 20 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? ___%

# PART A

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

## IN THE PAST TWO (2) YEARS:

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

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

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

Signature BOrkin, M.D. Date: 4, 9, 97

## I. PHYSICIAN INFORMATION

| BORIS | I | ORKIN | |
|---|---|---|---|
| *First Name* | *Middle Initial* | *Last Name* | *Suffix* |

*Make changes to name here*

Mass License # 51701
License Status Active

First Issue Date 10/14/83

1180 Beacon St. Ste 5B
Brookline, MA 02146-3806
U.S.A.
(617) 277-0090

Hospital Affiliation

St. Elizabeth's Medical Center
North Shore Medical Center-Salem Hosp
Faulkner Hospital
Newton-Wellesley Hospital
Beth Israel Hosp. of Boston

*Make address corrections here:*

*Make any corrections to above here:* add Beth Israel Hospital

Insurance Plan Affiliation:

Licenses Held in Other States:

NJ

*(Please correct as necessary)*

Accepting New Patients? ☐ Yes ☐ No

Accept Medicaid? ☐ Yes ☐ No

## II. EDUCATION & TRAINING

| Ivan-Frankovskij Medical Institute | MD | 72 |
|---|---|---|
| *Medical School* | *Degree* | *Date* |

*Make corrections here*

| St. Elizabeth's Med Ctr | 1985 | End 1987 |
|---|---|---|
| *Residency Program(s)* | *Start* | |
| UMDNJ | 1987 | End 1989 |
| *Residency Program(s)* | *Start* | |
| | | End |
| *Residency Program(s)* | *Start* | |

## III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

*Make any corrections here:*

## BOARD CERTIFICATION

Certifying Board Name:

Certifying Board Name:

*Make any corrections here:*

## IV. BOARD DISCIPLINE

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

| Nature | Date | Board Action |
|---|---|---|
| NONE | | |

## V. HOSPITAL DISCIPLINE

| Hospital | Date | Disciplinary Action |
|---|---|---|
| NONE | | |

## VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint NONE

## VII. MALPRACTICE

Details of claims paid for Dr. ORKIN

No. of Years in Practice: #

| | | | |
|---|---|---|---|
| Date NONE | Amount Paid 0.0000 | Basis for Complaint | |
| Date | Amount Paid | Basis for Complaint | |
| Date | Amount Paid | Basis for Complaint | |
| Date | Amount Paid | Basis for Complaint | |
| Date | Amount Paid | Basis for Complaint | |
| Date | Amount Paid | Basis for Complaint | |

## VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

| Awards, Honors | Publications |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***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) 727-3086, ext. 320

# Physician Registration Renewal Application

RECEIVED
APR 1999

RECEIVED
APR 9 1999
Board of Registration in Medicine

**Before proceeding, please read the instruction booklet.**
• Copy this form and all attachments for your own records, you will need copies for credentialing and other purposes.
• **Remit $250.00 for renewal fee.** APR 2 1 1999 • **Return renewal application in [illegible] envelope.**
• **Add late fee of $25.00, if necessary** • **Enclose check with coupon in [illegible]**

Registration No 51701 Renewal Date. 06/12/1999 1 Current Status Acti[illegible]

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

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

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

3 A) Mailing/Home Address:

[redacted]

B) Business Address:
1180 BEACON STREET
SUITE 5B
BROOKLINE, MA 02146-3806

Home Phone
Business Phone (617)277-0090

4 A) Date of Birth Sex M
B) SS#

5 A) Name of Medical School:
Ivan-Frankovskij Medical Institute

B) Year Graduated 1972 C) Degree MD

6 Specialty Code(s) (See Table 1)

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

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

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

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

**Please make corrections (type or print)**

Other Name(s) _____

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

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

Home ( )
Business ( ) _____

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

Full Name of Medical School
_____
_____

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

| Code(s) | Hours Per Week in Massachusetts |
|---|---|
| _____ | _____ |
| _____ | _____ |
| If OS, Print Specialty | _____ |

Code _____ Code _____

Federal (DEA) _____
Mass _____

Abbr _____

Abbr _____

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

PRINT NAME AND NUMBER: Last Name ORKIN Registration Number 51701

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

Facility Code 441 / ✓ (AP) 90.0 % Facility Code 85 / ✓ (AP) ____ % Facility Code 75 / ✓ (AP) ____ %

Facility Code 14 / ✓ (AP) ____ % Facility Code 49 / ✓ (AP) ____ % Facility Code ____ / ____ (AP) ____ %

If 999, print name(s) Repro Associates (107e

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

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)

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

Please explain exemption ____

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

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

B Care of patients in Massachusetts (see instruction booklet)

1) Average weekly hours involved in a) outpatient care 30 hrs/wk b) inpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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

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

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

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

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

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

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

Signature B Orkin, M.D. Date 4/6/99

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

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

# Physician Registration Renewal Application

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

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

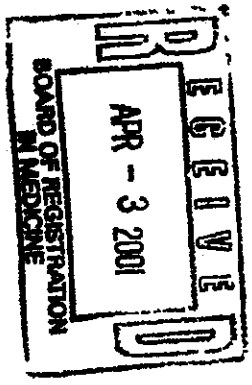
***Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required***

1 Current Status Active Registration No 51701 Renewal Date 06/12/2001

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

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

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




3 A) Mailing/Business Address
BORIS JORKIN

B) Home Address.

Home Phone

Business Phone

**Please make corrections** (type or print)

Other Name(s) _____

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

Business Address 1180 Beacon St. Ste 5B
City/Town Brookline State MA
Zip 02446 Country USA
Business Telephone (617) 277-0090

Home Address _____
City/Town _____ State ____
Zip _____ Country ____
Home Telephone

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

4 a) Date of Birth b) Sex M

c) SS#

5 a) Name of Medical School

b) Year Graduated 1972 c) Degree M D

6 Specialty Code(s) (See Table 1)

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

7 Current American Board of Medical Specialties Certification (See Table 2)

Code Code

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

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

NJ

b) States where you were previously licensed (Abbr)

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

Facility Code 441 / (AP) 100 % Facility Code 537 / 0 (AP) ____ % Facility Code 48 / (AP) 0 %
Facility Code 95 / (AP) 0 % Facility Code 75 / 0 (AP) ____ % Facility Code ____ / (AP) ____ %
If 999, print name(s) _____

PRINT YOUR LAST NAME ORKIN LICENSE NUMBER: 51701

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

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

Please explain exemption _____

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

13 A What is your principal work setting? (See Table 4) ____ ____

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

1) Average weekly hours involved in a) outpatient care 35-40 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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

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

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

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

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

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

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

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

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

Signature BOrkin, 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, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

Rec. 5-27-03

# Physician Registration Renewal Application

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

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

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

1. *Current Status:* Active Registration No. 51701 Renewal Date: 06/12/2003

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

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

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

A) Mailing/Business Address:

3. BORIS I ORKIN

B) Home Address:

Home Phone:

Business Phone: (617) 277-0090

**Please make corrections** (print)

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

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

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

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

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

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

5. a) Name of Medical School:
Ivan-Frankovskij Medical Institute
b) Year Graduated: 1972 c) Degree: M.D.

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

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

0

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

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

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

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

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

Facility Code: 441 / (AP) 90 % Facility Code: 537 / (AP) ____ % Facility Code: 48 / (AP) ____ %
Facility Code: 85 / (AP) ____ % Facility Code: 75 / (AP) ____ % Facility Code: ____ / (AP) ____ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: ORKIN LICENSE NUMBER: 51701

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

Insurer's name. (Required): _____ Policy dates: From: __/__/__ To: __/__/__

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

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1525 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 40 hrs/wk

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

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

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

| | YES | NO |
|---|---|---|

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

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

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

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

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

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

Signature: [signature] M.D Date: 5/12/03

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

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

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

# Massachusetts Physician Renewal Application

Physician Name: BORIS I OREKIN License No.: 51701

**PART A**

1) Current Status: Active Renewal Due Date: 05/15/2005 Birth Date:

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

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

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

2a) MAILING ADDRESS

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

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

*Home address cannot be a Post Office Box*

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
1180 BEACON STREET
SUITE 5B
BROOKLINE, MA 02446

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

*Business address cannot be a Post Office Box*

Phone: (617)277-0090

☐ *Check here to change this address*

2005 APR 25 PM 3:11
RECEIVED
BOARD OF REGISTRATION IN MEDICINE

RECEIVED
MAY - 4 2005
BOARD OF REGISTRATION IN MEDICINE

3) E-mail Address: _____

4) Fax Number: (617) 277-4535

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

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

List Certifying Board(s) below:

| Board Name | ABMS | AOA |
|---|---|---|
| ABOG | ☒ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

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

| Certificate/Subspecialty | Current? | Delete? |
|---|---|---|
| Obstetrics & Gynecology | ☒ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

# Massachusetts Physician Renewal Application

Physician Name: BORIS I ORKIN License No.: 51701

*(See Renewal Instructions, page 4.)*
7) Drug License Numbers, if any:
a) Massachusetts:
b) Federal (DEA):
c) Federal (DEA) XS:

*Please make corrections as necessary*
8a) Other states where you are NOW licensed to practice (Abbr.)
8b) States where you were previously licensed (Abbr.) NJ

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*
Principal Work Setting: Private Office Change to:
Please enter the approximate number of work hours at your principal work setting: 25-30

4/29/05 BOK

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 6 on Page 16 of the instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the approximate number of work hours for each Health Care Facility below:

| Health Care Facility *(See Renewal Instructions, page 4.)* | Delete? | Staff Category Current | Staff Category Change | Approximate # Hours per Week |
|---|---|---|---|---|
| Beth Israel Deaconess Medical Center | ☐ | Admitting | | 20 |
| Newton-Wellesley Hospital | ☐ | Admitting | | 0 |
| Other | ☐ | | | |
| St. Elizabeth's Medical Ctr of Boston | ☐ | Admitting | | 0 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: ____ hrs/wk
b) outpatient care 40 hrs/wk Change to: ____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*
My medical liability insurance is provided through: (check one)

☒ Insurance Carrier *(complete below)*
Current Insurance Carrier: CRICO Change to:
Policy dates: From 1/01/5 To 12/31/05 *(required)*

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

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

Check one:
☐ Not involved with direct or indirect patient care in Massachusetts
☐ Government Employee Federal Tort Claims Act (FTCA)
☐ Otherwise exempt *(Please explain)*:

# Massachusetts Physician Renewal Application

Physician Name: BORIS I-ORKIN License No.: 51701

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

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

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

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

22) CME CERTIFICATION:
a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
b) If no, are you requesting a CME waiver?
☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*
c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*
CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

# Massachusetts Physician Renewal Application

Physician Name: BORIS I ORKIN License No.: 51703

4/29/05

## PHYSICIAN PROFILE

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

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

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

## CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

***Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.***

Signature: B Orkin, M.D. Date: 4.5.05

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

# Massachusetts Physician Renewal Application

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

## PART A

1) **Current Status:** Active **Renewal Due Date:** 05/15/2007 **Birth Date:**

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

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

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

**2a) MAILING ADDRESS**

☐ *Check here to change this address*

**2b) HOME ADDRESS**

RECEIVED
APR - 2 2007
RECEIVED
APR 13 2007
Board of Registration in Medicine

☐ *Check here to change this address*

**2c) BUSINESS ADDRESS**
1180 Beacon Street
Suite 5b
Brookline, MA 02446

Phone: (617)277-0090

☐ *Check here to change this address*

**Please make corrections (print)**

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

**Home Address:** _____
**City/Town:** _____ **State:** _____
**Zip:** _____ **Country:** _____
**Home Telephone:** (___) _____
*Home address cannot be a Post Office Box*

**Business Address:** _____
**City/Town:** _____ **State:** _____
**Zip:** _____ **Country:** _____
**Business Telephone:** (___) _____
*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 617-277-4535

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

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

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

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

# Massachusetts Physician Renewal Application

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

## PART A

1) **Current Status:** Active **Renewal Due Date:** 05/15/2007 **Birth Date:**

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

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

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

**Please make corrections (print)**

**2a) MAILING ADDRESS**

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___)_____

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**

1180 Beacon Street
Suite 5b
Brookline, MA 02446

Phone: (617)277-0090

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___)_____

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 617-277-4535

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

_____

_____

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

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

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

# Massachusetts Physician Renewal Application

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

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

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

| List the names of all work sites in Massachusetts *(See above and description on page 4.)* | Location (City or Town) | State | Delete? |
|---|---|---|---|
| Beth Israel Deaconess Medical Center | | | ☐ |
| Newton-Wellesley Hospital | | | ☐ |
| St. Elizabeth's Medical Ctr of Boston | | | ☑ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

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

b) outpatient care 40 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** *(complete below)*

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 01/01/2007 To 01/01/2007

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

# Massachusetts Physician Renewal Application

**Physician Name: 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**<br>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).<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Have any criminal offenses/charges against you been resolved during this time period?<br>c) Are there any criminal charges pending against you today?<br>d) Are any Applications for Issuance of Process pending against you? | | |
| **18) INVESTIGATIONS AND DISCIPLINARY ACTIONS**<br>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?<br>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?<br>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?<br>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? | | |
| **19)** Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| **20)** Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? | | |
| **21)** Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? | | |

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

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

## PART C

**Check One:** **PHYSICIAN PROFILE**

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

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

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

**CERTIFICATIONS**

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: B Orkin, M.D Date: 3/28/07

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

# Massachusetts Physician Renewal Application

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

## NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

**In order for your license to be renewed you must take one of the following actions:**

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

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

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

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

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

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

☑ My current NPI is: 1 4 2 7 0 5 9 3 3 8

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

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

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

☐ As an *inactive* physician, I do not wish to obtain an NPI.

## HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

| | Taxonomy (Specialty) Code | Taxonomy Description (Print) |
|---|---|---|
| Primary Provider Taxonomy: | 2 0 7 V G 0 4 0 0 X | OBSTETRICS & GYNECOLOGY-HYSTERECTOMY |
| Provider Taxonomy: | | |
| Provider Taxonomy: | | |

## NPI REQUIRED INFORMATION

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

Social Security Number:

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

Gender: ☐ Male ☐ Female

### Penalties for Falsifying Information on the National Provider Identifier Application

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

### Authorization for NPI Dissemination

**Check one box:** ☑ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI 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.**

Signature: B Orkin, M.D. Date: 3/28/07

# Massachusetts Physician Renewal Application

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

04/28/09 S1 72

## 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.)

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

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

**Please make corrections (print)**

**2a) MAILING ADDRESS**

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___)_____

*Home address cannot be a Post Office Box*

APR 22 2009
Board of Registration in Medicine

**2c) BUSINESS ADDRESS**
1180 Beacon Street
Suite 5b
Brookline, MA 02446

Phone: (617)277-0090

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___)_____

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 617-277-4535

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

_____

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

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

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

# Massachusetts Physician Renewal Application

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

04/23/09 S1 73

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

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

| List the names of all work sites in Massachusetts *(See above and description on page 4.)* | Location (City or Town) | State | Delete? |
|---|---|---|---|
| Beth Israel Deaconess Medical Center | Boston | | ☐ |
| Newton-Wellesley Hospital | | | ☒ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

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

b) outpatient care 40 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** *(complete below)*

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2009 To 12/31/2009

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

CONTROLLED RISK INSURANCE COMPANY OF VERMONT INC. (A Risk Retention Group)
Burlington, 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 referenced 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" referenced below, regardless of the number of different capacities in which such person, organization or entity might qualify as an "Insured".

| | | |
|---|---|---|
| **Professional Liability:** | **Limits of Liability:** | |
| | $5,000,000.00 | each "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 terms, conditions and exclusions, including the limits of liability may be subject to change effective 01/01/2010.

Coverage terminates 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 Podiatrists maintained by the Risk 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, Massachusetts, 02142, agent of the Named Insured.

Controlled Risk Insurance Company of Vermont, Inc.

Alison B Jones

Alison B Jones
Duly Authorized Representative

051231

# Massachusetts Physician Renewal Application

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

04/22/08 S1 75

**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**<br>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).<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Have any criminal offenses/charges against you been resolved during this time period?<br>c) Are there any criminal charges pending against you today?<br>d) Are any Applications for Issuance of Process pending against you? | | |
| **18) INVESTIGATIONS AND DISCIPLINARY ACTIONS**<br>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?<br>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?<br>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?<br>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? | | |
| **19)** Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| **20)** Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? | | |
| **21)** Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? | | |

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

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

04/23/08 S1

## 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 seq*. I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

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

**Check One:** **PHYSICIAN PROFILE**

- ☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- ☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions, page* 11.)

***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: B Orkin, M.D. Date: 4/21/2009

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

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Renewal Application

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

**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 | Certification | Subspecialty |
|---|---|---|---|
| ABMS | Obstetrics & Gynecology | Obstetrics and Gynecology | |

**7) Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

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

**9) States where you were previously licensed**
New Jersey

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

| WorkSite | Location |
|---|---|
| Beth Israel Deaconess Medical Center | |

**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?**

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

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

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

## Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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