

Massachusetts Physician Renewal Application

Physician Name: **Marcus T Gordon, M.D.**

License No.: **82013**

REDACTED COPY
07/28/08 83
81

PART A

1) **Current Status:** Active **Renewal Due Date:** 07/14/2008 **Birth Date:**
 If you want to change your current status, please check one of the following boxes to indicate your new status:
Check only one: (See Renewal Instructions, page 3.)
 Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

North Shore Women's Center
 480 Lynnfield St. 2nd Floor
 Lynn, MA 01904

RECEIVED

JUL 25 2008

Board of Registration
 in Medicine

Check here to change this address

2b) HOME ADDRESS

Phone:

Check here to change this address

2c) BUSINESS ADDRESS

North Shore Women's Center
 480 Lynnfield St. 2nd Floor
 Lynn, MA 01904

Phone: (781)595-4800

Check here to change this address

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

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

4) **Fax Number:** 781-595-3843

| 5) Specialties (See Renewal Instructions, page 4.) | Delete? | List Additional Specialties: |
|--|--------------------------|------------------------------|
| Obstetrics and Gynecology | <input type="checkbox"/> | |
| | <input type="checkbox"/> | |
| | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |
| | | | <input type="checkbox"/> |

Massachusetts Physician Renewal Application

Physician Name: **Marcus T Gordon, M.D.**

License No.: **82013**

07/28/08 83 82

| | |
|--|--|
| <p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers Corrections:</p> <p>a) Massachusetts: _____</p> <p>b) Federal (DEA): _____</p> <p>c) Federal (DEA) XS: _____</p> | <p style="text-align: center;"><i>Please make corrections as necessary</i></p> <p>8) Other states where you are <u>now</u> licensed to practice</p> <p style="text-align: center;">_____</p> <p>9) States where you were <u>previously</u> licensed</p> <p style="text-align: center;">NY IL _____</p> |
|--|--|

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 <i>(See above and description on page 4.)</i> | Location (City or Town) | State | Delete? |
|--|----------------------------|-------|--------------------------|
| North Shore Medical Center - Salem Hospital | | | <input type="checkbox"/> |
| Union Hospital | Lynn, MA | MA | <input type="checkbox"/> |
| Merrimack Valley Women's Health Services | Methuen, | MA | <input type="checkbox"/> |
| Four Women Health Services | Attleboro | MA | <input type="checkbox"/> |
| _____ | _____ | | <input type="checkbox"/> |
| _____ | _____ | | <input type="checkbox"/> |

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

Average weekly hours involved in: a) inpatient care 10 hrs/wk Change to: _____ hrs/wk

b) outpatient care 35 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: ProMutual Group Change to: _____

Policy dates: From 1/22/08 To 1/22/09

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.

07/28/08 83 83

MEDICAL PROFESSIONAL MUTUAL INSURANCE COMPANY CERTIFICATE OF INSURANCE

July 21, 2008

This is to certify that the following policies, subject to the terms, conditions, and exclusions have been issued by this Association. The Association will mail to the party whom this Certificate is issued a record of any material changes in or cancellation of said policy or policies, but takes no responsibility for failure to do so.

NAME AND ADDRESS OF PARTY TO WHOM CERTIFICATE IS ISSUED:

NAMED INSURED:

Marcus T. Gordon, MD

| Type of Insurance | Policy Number | Policy Eff. Date | Policy Exp. Date | Limits | |
|------------------------------------|---------------|------------------|------------------|---|---------------|
| | | | | General Aggregate | \$ |
| | | | | Products Completed/Operations Aggregate | \$ |
| | | | | Personal & Advertising Injury | \$ |
| | | | | Each Occurrence | \$ |
| | | | | Fire Damage (Any One Fire) | \$ |
| | | | | Medical Expense (Any One Person) | \$ |
| Professional Liability Claims Made | 1-23186 | 01/22/08 | 01/22/09 | Each Claim | \$ 1,000,000. |
| | | Retro Date: | 01/01/1998 | Annual Aggregate | \$ 3,000,000. |

REMARKS:

This Certificate of Insurance neither affirmatively nor negatively amends, extends, or alters the coverage afforded by these policies.

Date: 07/21/2008

Michael R. Chapman

By:

Massachusetts Physician Renewal Application

Physician Name: **Marcus T Gordon, M.D.**

License No.: **82013**

07/28/08 33

34

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

| | |
|---|--|
| <p>14) CLAIMS MADE</p> <p>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).</p> <p>b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?</p> | |
| <p>15) CLAIMS CLOSED</p> <p>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?</p> | |
| <p>16) OTHER CIVIL LAWSUITS</p> <p>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.</p> <p>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?</p> <p>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</p> | |
| <p>17) CRIMINAL CHARGES</p> <p>a) Have you been charged with any criminal offense during this time period?</p> <p>b) Have any criminal offenses/charges against you been resolved during this time period?</p> <p>c) Are there any criminal charges pending against you today?</p> <p>d) Are any Applications for Issuance of Process pending against you?</p> | |
| <p>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</p> <p>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</p> <p>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?</p> <p>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?</p> <p>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?</p> | |
| <p>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?</p> | |
| <p>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?</p> | |
| <p>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?</p> | |
| <p>22) CME CERTIFICATION:</p> <p>a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A CME waiver request form must be submitted at least 30 days prior to your license expiration date.</p> <p>c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)</p> <p>CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training</p> | |

Massachusetts Physician Renewal Application

Physician Name: Marcus T Gordon, M.D.

License No.: 82013

07/28/08 53

85

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: _____

Date: 7/21/08

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



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

Physician Name: Marcus T Gordon, M.D.

License No.: 82013

Current Status: Active

License Expiration Date: 8/11/2010

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: North Shore Women's Center
480 Lynnfield St. 2nd Floor
Lynn
Massachusetts - 01904
United States of America

Home Address:

Business Address: North Shore Women's Center
480 Lynnfield St. 2nd Floor
Lynn
Massachusetts - 01904
United States of America
(781) 595-4800

3) Email Address:

4) Fax Number: (781) 595-3843

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
Illinois
New York

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 |
|----------------------------|-----------|
| Four Women Health Services | Attleboro |



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Marcus T Gordon, M.D.

License No.: 82013

Merrimack Valley Health Services, Inc
North Shore Medical Center - Salem Hospital

Methuen

Union Hospital

Lynn

11) Care of patients in Massachusetts
Average weekly hours involved in:

- a) inpatient care 10 hrs/wk
- b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|------------------------------------|-------------------|-----------------|-------------------|
| Medical Professional Mutual Ins Co | 01/22/2010 | 01/22/2011 | 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?



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

Physician Name: Marcus T Gordon, M.D.

License No.: 82013

-
- 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 you are renewing your license for the first time, please answer Yes)
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Marcus T Gordon, M.D.

License No.: 82013

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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