approved 6/29/88 1st Mass. app.

BOARD OF REGISTRATION IN MEDICINE

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks) 18570

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.
LIC # 95479

FOR OFFICE USE
Date Received 6-23-88
Certificate #
By: Carol Form of Fee: CK

SECTION A: Sworn statement to be completed by applicant. Please type or print.

REDACTED COPY

Name: Marcus (First) Tulio (Middle) Gordon (Last)
Date of Birth:

Mailing Address: Boston City Hospital
House Officers Reg. 818 Harrison Avenue, Boston, MA 02118

Pre-medical School: City College of New York
Medical School: Albert Einstein College of Medicine

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? NO
(give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?		
2.	Have you ever been denied a medical license?		
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?		
4.	Have you ever failed an examination before a State Medical Board?		
5.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		
6.	Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff?		
7.	Have you ever been a patient for the treatment of a mental illness?		
8.	Have you ever been under treatment for drug dependency or alcoholism?		
9.	Has a judgement ever been returned against you in a malpractice suit?		
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?		

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Marcus Tulio Gordon DATE: 5/18/88

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that Marcus T. Gordon has been appointed to the position of PGY-2 in Boston City Hospital (Name of Hospital)
beginning July 1, 1988 and ending June 30, 1988.

Is the purpose of this application participation in a training program? Yes (yes or no)
If yes, is this program ACGME or RRC accredited? Yes (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? _____ (yes or no)

Maxine Kessler, Director Physicians Services — 6/20/88
SIGNATURE — OFFICIAL CAPACITY — DATE

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): N.Y., Illinois

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	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 a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) 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? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
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 any 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 been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature: Marcus Kaplan **Date:** 6/1/90

FORM 11/89

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
LIMITED LICENSE

FOR OFFICE USE ONLY
Limited License Application ___
Pending ___ Approved ___
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Marcus Gordon, M.D.
PERMANENT ADDRESS: _____

LOCAL MAILING ADDRESS IN (MA): _____

HOSPITAL: Boston City Hosp, Tuft
ADDRESS: 818 Harrison Ave
Boston, Mass

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		✓
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		✓
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?		✓
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?		✓
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?		✓
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		✓
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?		✓
8. 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)?		✓
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.		✓
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?		✓
11. Have you ever for any reason, lost American Specialty Board Certification?		✓
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?		✓
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		✓
14. 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?		✓
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		✓
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		✓
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?		✓
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. New York, Illinois, _____, _____.	✓	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00 within 60 days of commencement of hospital appointment in the Commonwealth of Massachusetts. To the best of my knowledge I meet the qualifications for Limited Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Marcus Gordon DATE: 6/20/88

(SEE REVERSE SIDE)

COMMONWEALTH OF MASSACHUSETTS — 1st Mass. appl.

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks) #8570

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.
LIC # 95479

FOR OFFICE USE
Date Received 6-23-88
Certificate # _____
By: Carol Form of Fee: CK

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: Marcus (First) Tulio (Middle) Gordon (Last)
Date of Birth: ___ ___ ___

Mailing Address: Boston City Hospital
House Officers Reg. 818 Harrison Avenue, Boston, MA 02118

Pre-medical School: City College of New York
Medical School: Albert Einstein College of Medicine

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? NO
(give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?	1.	-
2.	Have you ever been denied a medical license?	2.	-
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	-
4.	Have you ever failed an examination before a State Medical Board?	4.	-
5.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?	5.	-
6.	Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff?	6.	-
7.	Have you ever been a patient for the treatment of a mental illness?	7.	-
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	-
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	-
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	-

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Marcus Tulio Gordon DATE: 5/18/88

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that Marcus T. Gordon has been appointed to the position of PGY-2 (2) in Boston City Hospital (Name of Hospital)

beginning July 1, 1988 (gmb) and ending June 30, 1989 (gmb).

Is the purpose of this application participation in a training program? Yes (yes or no)
If yes, is this program ACGME or RRC accredited? Yes (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? _____ (yes or no)

Maxine Kessler, Director Physicians Services 6/20/88
SIGNATURE OFFICIAL CAPACITY DATE

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
LIMITED LICENSE

FOR OFFICE USE ONLY
Limited License Application ___
Pending ___ Approved ___
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: MARCUS GOODSON, M.D.
PERMANENT ADDRESS: _____
_____
LOCAL MAILING
ADDRESS IN (MA): _____
_____

HOSPITAL: Boston City Hospital
ADDRESS: 818 Harrison Ave
Boston, MASS

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. *Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?*	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or *improper conduct during an examination since your matriculation* in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of *disciplinary action*?	7.	
8. 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)?	8.	
9. Have you ever voluntarily surrendered a license to *practice medicine or any healing art? The Board's regulations* define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. *Have you been denied required recertification by one or* more specialty boards? If yes, which one(s)?	12.	
13. *Have you, at any time, been a defendant in any criminal* proceeding other than minor traffic offenses?	13.	
14. 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?	14.	
15. *Have you ever had any emotional disturbance or mental* illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. New York, Illinois, _____, _____.	18.	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00 within 60 days of commencement of hospital appointment in the Commonwealth of Massachusetts. To the best of my knowledge I meet the qualifications for Limited Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Marcus Goodson DATE: 6/20/88

(SEE REVERSE SIDE)

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Limited License Application, Page 1 of 2

L10028

Board Use Only:

Registration No.	Status	Fee	Date
		$25	

M.R. ____ ____
Pr. ____ ____
Bk. Card 4/19/89
Ch. ____ ____
D.E. ____ ____
Fl. ____ ____

RECEIVED APR 1989

Important:
- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the 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.*

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ✓ 2) Graduate of Foreign Medical School ___ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___.

This is a (check one) 1) New Application ___ 2) Renewal ✓ If renewal, indicate current Limited License Number 95479 3) Change of Program ___

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

Applicants please circle one: I will be a PGY1 PGY2 PGY3 (PGY4) PGY5 PGY6 PGY7 Other (Specify): ____

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) GORDON (FIRST:) MARCUS (M.I.:) T

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, *please specify (and attach documentation):* ____

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: NO

2. a) Current Address (Mailing) (Valid Until ____): ____

2. b) New Address (Mailing) (Valid After ____): ____

2. c) Address (Work/Hospital): Boston City Hospital; 818 Harrison Ave Boston, Ma

2. d) Telephone (Work/Hospital): (617) 424-5000 Extension ____ 2. e) Telephone (Home): ____

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

6. a) Medical School Name: Albert Einstein College of Medicine

6. b) Year Graduated: 85 6. c) Degree: M.D. ✓ D.O. ___ Other (Specify) ____

6. d) Country: U.S. ✓ State NY Canada ___ Province ____ If Other write Name: ____

7. Specialty: Obstetrics & Gynecology

8. Name of Pre-medical School(s): City College of New York

Location: (City, State, Country) New York, N.Y.

9. Have you ever held a limited license in Massachusetts? Yes ✓ No ___ If yes, list the license numbers you have held and name the institutions involved: Number of Massachusetts limited licenses: 1 Names of the institutions involved and the registration numbers:

Boston City Hospital # 95479

10. If you have had any one of the following, please circle which one and attach an explanation to this form: 1) A leave of absence from medical school 2) More than four years of medical school education. Question 10 applies to me: Yes ___ No ✓ I have attached an explanation: Yes ___ No ___

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: Marcus Gordon Date: 3/8/89

(See reverse side - You must complete Section C)

FORM 1/89

Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

SECTION B: To be completed and signed by the Designated Official of the Institution at which the Applicant has received an appointment.

This certifies that Marcus Gordon has been appointed to the position of PGY 4 in

Specialty) Obstetrics & Gynecology at Boston CIty Hospital

Beginning July 1989 and ending June 1990.

This program is accredited by the ACGME: Yes X No__

If no, we have an ACGME approved training program in the applicant's specialty: Yes__ No__ Anticipated completion date of training

Program: June 1990

Designated Official's Signature: Maxine E. Kessler (FM)

Type or Print Name and Title: Maxine E. Kessler Adm. Director of Medical Affairs Date: 3/13/89

If renewal, I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes__ No X

Signature of Designated Official

Type or Print Name and Title: Kenneth C. Edelin, Director Date: 3/13/89

****

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

1. Other States where you are now licensed to practice (Abbreviate): N.Y., I.L

2. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate):

3. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes__ No✓ I have attached an explanation: Yes__ No__

4. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes__ No ✓ **If yes,** please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes__ No__ Program Director's Certification has been requested: Yes__ No__

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
5. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
3. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
'. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
:. 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?		
. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		
. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
Are you now, or have you been in the past, dependent upon alcohol or drugs?		
Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination, or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

****

89-1020-90

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Limited License Application, Page 1 of 2

Board Use Only: L10028

Registration No.	Status	Fee	Date
		$25	

M.R.		
Pr.		
Bk.	Card	4/19/89
Ch.		
D.E.		
Fl.		

RECEIVED APR 1989

Important:
- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the 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.*

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ✓ 2) Graduate of Foreign Medical School 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___

This is a (check one) 1) New Application ___ 2) Renewal ✓ If renewal, indicate current Limited License Number 95479 3) Change of Program ___

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

Applicants please circle one: I will be a PGY1 PGY2 PGY3 (PGY4) PGY5 PGY6 PGY7 Other (Specify): ___

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) GORDON (FIRST:) MARCUS (M.I.:) T

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation):

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: NO

2. a) Current Address (Mailing) (Valid Until ___)

2. b) New Address (Mailing) (Valid After ___):

2. c) Address (Work/Hospital): Boston City Hospital; 818 Harrison Ave Boston, Ma

2. d) Telephone (Work/Hospital): (617) 424-5000 Extension ___ 2. e) Telephone (Home):

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

6. a) Medical School Name: Albert Einstein College of Medicine

6. b) Year Graduated: 85 6. c) Degree: M.D. ✓ D.O. ___ Other (Specify) ___

6. d) Country: U.S. ✓ State NY Canada ___ Province ___ If Other *write* Name: ___

7. Specialty: Obstetrics + Gynecology

8. Name of Pre-medical School(s): City College of New York

Location: (City, State, Country) New York, N.Y.

9. Have you ever held a limited license in Massachusetts? Yes ✓ No ___ If yes, list the license numbers you have held and name the institutions involved: Number of Massachusetts limited licenses: 1 Names of the institutions involved and the registration numbers:

Boston City Hospital # 95479

10. If you have had any one of the following, please circle which one and attach an explanation to this form: 1) A leave of absence from medical school 2) More than four years of medical school education. Question 10 applies to me: Yes ___ No ✓ I have attached an explanation: Yes ___ No ___

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

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

Applicant's Signature: Marcus Gordon Date: 3/8/89

(See reverse side - You must complete Section C)

FORM 1/89

90-5089-91

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

X Renewal ___ Change of Program

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Check entered 7/5/90 $50.00 KMH

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

Bd cpg 6/27/90 KMH

M.R.	____	__/__/__
Pr.	____	__/__/__
Bk.	____	__/__/__
Ch.	____	__/__/__
D.E.	____	__/__/__
Fl.	____	__/__/__

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**

Sign the application at the bottom of page two.

- **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.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) GORDON (FIRST:) MARCUS (M.I.:) T
2. Mailing Address: _____
3. Name & Address of Training Hospital: Boston City Hospital
   818 Harrison Ave Boston Ma 02118
4. Current Limited License Number: 89-1020-90
5. **Change of Program Applicant:**

   List previous license numbers, Training Institutions and Programs involved:

   _____

   [illegible]

   _____

5a. Was previous training a prerequisite for entering into this program ____Yes ____No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: ____Yes ____No Program Director's Certification has been requested: ____Yes ____No.

6. **Renewal Applicant Only: To be completed by Program Director.**
I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes ____No.

Type or Print Name and Title _____

Signature of Program Director _____ Date 6/18/90

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Marcus Gordon has been appointed to the position of Intern ____, Resident ✓,

Fellow ____ in Program Obstetrics/Gynecology (Program) at Boston City Hospital (Institution) beginning July 1, 90 and

Anticipated completion date of training 6/30/91.

This program is accredited by the ACGME: Yes X No ___
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

Designated Official's Signature: Maxine E. Kessler

Maxine E. Kessler

Type or Print Name and Title: Admin. Dir., Medical Affairs Date 6/20/90

(Applicant See reverse side - You must complete Section C)

FORM 11/89

Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

SECTION B: To be completed and signed by the Designated Official of the Institution at which the Applicant has received an appointment.

This certifies that Marcus Gordon has been appointed to the position of PGY 4 in

(Specialty) Obstetrics & Gynecology at Boston CIty Hospital

beginning July 1989 and ending June 1990.

This program is accredited by the ACGME: Yes X No___

If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___ Anticipated completion date of training program: June 1990

Designated Official's Signature: Maxine E. Kessler (LM)

Type or Print Name and Title: Maxine F. Kessler Adm. Director of Medical Affairs Date: 3/13/89

If renewal, I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes___ No X

Signature of Designated Official

Type or Print Name and Title: Kenneth C. Edelin, Director Date: 3/13/89

****

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now licensed to practice (Abbreviate): N.Y., I I

12. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate):

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes___ No✓ I have attached an explanation: Yes___ No___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No✓ If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes___ No___ Program Director's Certification has been requested: Yes___ No___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	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 a defendant in any 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 Attached Form 15B) 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? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		
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 any 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 been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

****

90-5089-91

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

check entered 7/5/90 $50.00 KM

Limited License Application, Page 1 of 2

X Renewal ___ Change of Program

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

Bd 6/27/90 KM

M.R.	____	__/__/__
Pr.	____	__/__/__
Bk.	____	__/__/__
Ch.	____	__/__/__
D.E.	____	__/__/__
Fl.	____	__/__/__

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **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.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) GORDON (FIRST:) MARCUS (M.I.:) T
2. Mailing Address: _____
3. Name & Address of Training Hospital: Boston City Hospital
   818 Harrison Ave Boston Ma 02118
4. Current Limited License Number: 89-1020-90
5. **Change of Program Applicant:**

   List previous license numbers, Training Institutions and Programs involved:

   Illinois #036-076784 MS Stage Chicago, IL

5a. Was previous training a prerequisite for entering into this program ____Yes ____No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: ____Yes ____No Program Director's Certification has been requested: ____Yes ____No.

6. **Renewal Applicant Only: To be completed by Program Director.**
I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes ____No.

Type or Print Name and Title _____

Signature of Program Director _____ Date 6/18/90

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Marcus Gordon has been appointed to the position of Intern ____, Resident ✓,

Fellow ____ In Program Obstetrics/Gynecology (Program) at Boston City Hospital (Institution) beginning July 1, 90 and

Anticipated completion date of training 6/30/91.

This program is accredited by the ACGME: Yes X No
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

Designated Official's Signature: Maxine E. Kessler

Maxine E. Kessler

Type or Print Name and Title: Admin. Dir., Medical Affairs Date 6/20/90

(Applicant See reverse side - You must complete Section C)

FORM 11/89

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): N.Y., Illinois

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	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 a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) 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? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
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 any 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 been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature: Marcus Horton Date: 6/10/90

FORM 11/89

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: [redacted] Day time phone #: _____

MAILING ADDRESS: [redacted] Business Address:

Address valid until: 12/95

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. 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)? (You must complete Form 1B, attached, for each claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) 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. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
12. Have you ever, for any reason, lost American Specialty Board Certification?		
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: [redacted] DATE: 2-6-95

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Marcus Gordon Day time phone #: _____

MAILING ADDRESS: _____ Business Address:

#50-406

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. 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)? (You must complete Form 1B, attached, for each claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
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14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
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19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

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I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: Marcus Gordon DATE: 6-23-95

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: $350.00 TO BE SUBMITTED

Filed: 3/27/95
By: [illegible]
Form of Fee: _____

For Office Use
Application # _____
Certificate # 82013 Date of Issue 9/27/95

Please Print

SWORN STATEMENT

Date: 3-5-95

Name Marcus Tulio Gordon (First / Middle / Last)
Address _____

Date of Birth _____

Place of Birth Newyork, N.Y.

Name on Birth Certificate Marcus Tulio Gordon

Phone # _____

Pre-Medical Education

School City College of New York
Years Attended 1/76 - 6/81

Medical Education

School Albert Einstein College of Medicine
Years Attended 9/81 - 6/85

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Montefiore Medical Center,	Surgical Intern	7/85 - 7/86
Mt. Sinai Hospital	OB/GYN Resident	7/87 - 5-88
Boston City Hospital	OB/GYN Resident	7/88 - 10/90
St. Luke's - Roosevelt Hospital	OB/GYN Attending	3/91 - present
Jackson & Coker Locum Tenens		12/90 - 3/91

Is this your first full license? No If applicable, please list all other states where you are or have been licensed:
New York, Illinois

Other names under which you have been licensed:

List Specialty Boards by which you are certified: Diplomate of the American Board of Obstetrics and Gynecology

REASON APPLYING FOR A MA LICENSE seeking a position in Boston
Anticipated starting date if you have position pending in Massachusetts: __/__/__ correction position pending start date 7/1/95

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

RECEIVED
MAR 27 1995
BOARD OF REGISTRATION IN MEDICINE

AFFIDAVIT OF APPLICANT:
I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a truthful statement made under penalty of perjury.

Marcus Gordon
SIGNATURE OF APPLICANT

Date: 2/6/95

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Hugues Gaeton Day time phone # _____

MAILING ADDRESS: _____ Business Address: _____

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

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	YES	NO
1. 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)? (You must complete Form 1B, attached, for each claim)		
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I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: _____ DATE: 6-23-95

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Marcus T. Gordon MD Day time phone #:

MAILING ADDRESS: _____ Business Address:

Address valid until: 6/'95

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

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19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

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I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: Marcus Gordon DATE: 2-6-95

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
82013	ACTIVE	$250.00	08/11/96	$25.00

Mailing Address:

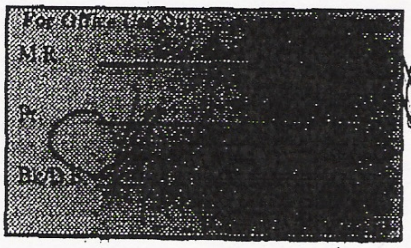
MARCUS T GORDON, M.D.

Correction of Mailing Address

Address (Mailing): 1101 Boylston Street
City/Town: Chestnut Hill
State: MA 02167
Country: U.S.

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.*



Pre-Printed Information

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

2. Home Address:

3. Date of Birth:
   Lic. Issue Date: 09/27/95
   Sex: M
   SS#:

   Home Phone ( ) -
   Business Phone ( ) -

4. Name of Medical School:
   Albert Einstein College of Medicine
   Yeshiva Univ
   Year Graduated: 85 Degree: MD

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

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

Code	Hours per Week in Mass.
OBG	20

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

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

Corrections of Pre-Printed Information

Name: Marcus T. Gordon, M.D.
Address:
City/Town:
State: Zip:
Country:

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

Home: Business: (617) 430 1068

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.**

LLS

PRINT NAME AND NUMBER: Physician Last Name: Gordon Registration Number: 82013

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: 999 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): Planned Parenthood of MA.

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

If 999, write name(s): Preterm Health Services

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

List Insurer: Medical Professional Mutual Insurance Co.

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) 25

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? 20 hrs/wk

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

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

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: [signature] Date: 6/25/96

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

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.**

JUN 1 9 1998 CHT

Registration No.: 82013 Renewal Date: 08/11/1998

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

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

3. A) Mailing/Home Address:

MARCUS T GORDON, M.D.
1101 BOYLSTON STREET
CHESTNUT HILL, MA 02167

B) Business Address:

Home Phone:
Business Phone: ( ) -

4. A) Date of Birth: Sex: M
B) Lic. Issue Date: 09/27/95 D) SS#:

5. A) Name of Medical School:

Albert Einstein College of Medicine
Yeshiva Univ
B) Year Graduated: 1985 C) Degree: MD

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass.

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: NY IL
B) States where you previously were licensed to practice
Abbr:

Corrections (type or print)

Other Name(s):

Mailing Address: North Shore Women's Center, P.C.
City/Town: 583 Chestnut St; Lynn State: MA
Zip: 01904 Country: U.S.

Other Address:
City/Town: State: MA
Zip: Country: U.S.

Home: ( )
Business: (781) 595 4800

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: ~~OBG~~ 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: Marcus Gordon, MD Registration Number: 82013

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: 81 (AP) Facility Code: / (AP) Facility Code: / (AP)
Facility Code: 71 (AP) Facility Code: / (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: 996 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: Medical Professional Mutual Ins Co.

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 25 10

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

1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 6 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 25 %

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 _____ Date: 6/16/98

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

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

Registration No.: 82013 Renewal Date: 08/11/2000 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
MARCUS T GORDON
NORTH SHORE WOMEN'S CTR
583 CHESTNUT STREET
LYNN, MA 01904

B) Home Address:

RECEIVED JUL 14 2000 Board of Registration in Medicine

Home Phone:
Business Phone: 781 595 4800

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

5. A) Name of Medical School: Albert Einstein College of Medicine Yeshiva Univ
B) Year Graduated: 1985 C) Degree: M.D.

6. Specialty Code(s) (See Table 1) Hours per Week in Mass.
Code(s) 0 Obstetrics and Gynecology
0

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: (781) 595 4800

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:	_____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr: NY IL

B) States where you previously were licensed to practice
Abbr:

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: GORDON Registration Number: 82013

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: 411 ✓ (AP) 90 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

Facility Code: 141 ✓ (AP) 8 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

If 999, print name(s): _____

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

Name of Insurer: Medical Professional Mutual Ins. Co. 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) 1 5

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

1) Average weekly hours involved in: a) outpatient care 30 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 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: _____ Date: 7/12/00

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

RECEIVED
AUG – 2 2002
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. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

- Remit $400.00 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.: 82013 Renewal Date: 08/11/2002

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:

3. A) Mailing/Business Address:
MARCUS T GORDON
NORTH SHORE WOMEN'S CTR.
480 Lynnfield St. 2nd Floor
LYNN, MA 01904

B) Home Address:

Home Phone:

Business Phone: 781 595 4800

Please make corrections (type or print)

Other Name(s): _____

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: 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:
Albert Einstein College of Medicine Yeshiva Univ
b) Year Graduated: 1985 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.)
NY IL
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: 538/ (AP) 98 % Facility Code: ___/ (AP) ___% Facility Code: ___/ (AP) ___%
Facility Code: 537/ (AP) 2 % Facility Code: ___/ (AP) ___% Facility Code: ___/ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: GORDON LICENSE NUMBER: 82013

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: _____ 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) 1 5
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 20 %

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: _____ Date: 7/31/09

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

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 *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 coupon 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.: 82013 Renewal Date: 08/11/2004

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:

3. A) Mailing/Business Address:
Marcus T Gordon
North Shore Women's Center
480 Lynnfield St. 2nd Floor
Lynn, MA 01904

JUN 16 2004

B) Home Address:

Home Phone:

Business Phone: (781)595-4800

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: 02467 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:
Albert Einstein College of Medicine Yeshiva Univ
b) Year Graduated: 1985 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	20	Obstetrics and Gynecology

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.)
NY IL
b) States where you were previously licensed (Abbr.)

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: 537 ✓ (AP) 100 % Facility Code: ___ ___ /___ (AP) ____% Facility Code: ___ ___ /___ (AP) ____%
Facility Code: ___ ___ /___ (AP) ____ % Facility Code: ___ ___ /___ (AP) ____% Facility Code: ___ ___ /___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: GORDON LICENSE NUMBER: 82013

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

Insurer's name. (Required): Promutual Group Policy dates: From: 1/22/04 To: 1/22/05

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) 45 ____ 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 10 hrs/wk B) outpatient care 35 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 (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: _____ Date: 6/17/04

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.

Massachusetts Physician Renewal Application

Physician Name: Marcus T Gordon **License No.:** 82013

PART A

1) Current Status: Active **Renewal Due Date:** 07/14/2006 **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

☐ *Check here to change this address*

RECEIVED
JUL 14 2006
Board of Registration in Medicine

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

2b) HOME ADDRESS

RECEIVED
JUL 27 2006
Board of Registration in Medicine

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

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

Phone: (781)595-4800

☐ *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: (781) 595-3843

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

Massachusetts Physician Renewal Application

Physician Name: Marcus T Gordon **License No.:** 82013

PART A

1) Current Status: Active **Renewal Due Date:** 07/14/2006 **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

☐ *Check here to change this address*

RECEIVED
JUL 14 2006
Board of Registration in Medicine

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

2b) HOME ADDRESS

RECEIVED
JUL 27 2006
Board of Registration in Medicine

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

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

Phone: (781)595-4800

☐ *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: (781) 595-3843

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

Massachusetts Physician Renewal Application

Physician Name: Marcus T Gordon **License No.: 82013**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	~~NY~~ ~~IL~~
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	NY IL

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: 30

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

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

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
North Shore Medical Center - Salem Hospital } same institution	☐	✓		0
Salem Hospital	☐	✓		0
Union Hospital	☐	✓	~~10~~	10
	☐			
	☐			
	☐			
	☐			

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.)*

My medical liability insurance is provided through: (check one)

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 1/22/06 To 1/22/07 *(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: Marcus T Gordon **License No.: 82013**

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		
a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim?		
b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.		
a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?		
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES		
a) Have you been charged with any criminal offense during this time period?		
b) Are there any criminal charges pending against you today?		
c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

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

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