



THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

REDACTED COPY

FEE: \$350.00 TO BE SUBMITTED

Filed: 14 For Office Use Application # _____
By: PS
Form of Fee: 350 Certificate # 81013 Date of Issue 4/12/95

Please Print

SWORN STATEMENT

Date: _____

Name VIRGINIA ANN SIEGFRIED Address _____
First Middle Last
Date of Birth _____
Place of Birth Redwood City, Calif.
Name on Birth Certificate Virginia Ann Siegfried Phone # _____
Pre-Medical Education Medical Education
School Stanford University School Columbia University
Years Attended 9/73 - 6/75 Years Attended 9/75 - 6/79

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

Place	Position	Dates
<u>UCLA Hospital</u>	<u>Internship - OB/GYN</u>	<u>7/79 - 6/80</u>
<u>UCLA Hospital</u>	<u>Residency - OB/GYN</u>	<u>7/80 - 6/83</u>
<u>Cedars Sinai Hosp. - LA</u>	<u>Private practice</u>	<u>7/83 - present</u>

Is this your first full license? NO If applicable, please list all other states where you are or have been licensed: California

Other names under which you have been licensed:

List Specialty Boards by which you are certified: American College of Obstetrics & Gynecology 12/85

REASON APPLYING FOR A MA LICENSE Relocation
Anticipated starting date if you have position pending in Massachusetts: 6/1/95

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

AFFIDAVIT OF APPLICANT:

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

Virginia Siegfried Date: 12/29/94
SIGNATURE OF APPLICANT

RECEIVED
JAN - 4 1995
BOARD OF REGISTRATION
IN MEDICINE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Virginia Siegfried Day time phone #: 310 394-0294

MAILING ADDRESS: _____ Business Address: 150 No. Robertson Blvd #200 Beverly Hills, Calif. 90211

Address valid until: current

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: Virginia Siegfried DATE: 12-29-94

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
81013 ACTIVE \$250.00 09/22/95 \$25.00

Mailing Address:
VIRGINIA ANN SIEGFRIED, M.D.

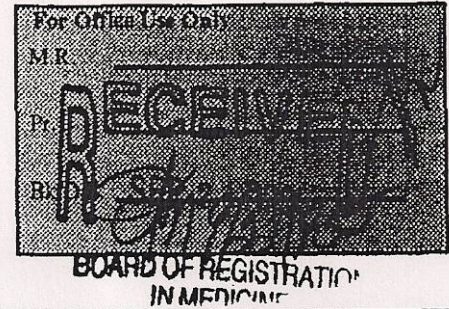
Correction of Mailing Address

Address (Mailing): _____

 City/Town: _____
 State: _____
 Country: _____

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

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



Pre-Printed Information

1. Other name(s), if any, under which you were licensed:
2. Home Address:
3. Date of Birth: _____ Sex: **F**
 Lic. Issue Date: **04/12/95** SS#: _____
- Home Phone _____ Business Phone **(603) 778-0557**
4. Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
 Year Graduated: **79** Degree: **MD**
5. a) Other states where you are now licensed to practice (Abbr): **CA**
 b) States where you previously were licensed to practice (Abbr):

Corrections of Pre-Printed Information

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

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

Home: () _____ Business: () _____

Full Name of Medical School: _____

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

NH _____

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

Code	Hours per Week in Mass.
<u>OBG</u>	<u>0</u>
_____	_____
_____	_____

If OS, print specialty: _____

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

Code: _____ Code: _____

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

Federal (DEA): _____
 Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: SIEGFRIED Registration Number: 81013

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: 998 / (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)
Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

If 999, print name(s): _____

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

Facility Code: 998 Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write name(s): _____

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

List Insurer: Medical Mutual of Maine

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) 5 _____

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? 0 hrs/wk

ii) How many hours per typical week are you currently involved in inpatient care in Mass? 2 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? 50 %
(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: Heinrich Siegfried

Date: 9/19/95

PRINT NAME AND NUMBER: Last Name: SIEGFRIED Registration Number: 81013

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: 998 (AP) Exeter Hosp Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
Facility Code: ___ / ___ (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: ___ 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 Mutual Insurance Company of Maine

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) WH 20

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

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

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

PART A

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

IN THE PAST TWO (2) YEARS:

YES	NO

- 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
- 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
- 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?
- 17. Have you been charged with any criminal offense, other than a minor traffic violation?
- 18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
- 19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
- 20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
- 21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
- 22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)?
 Waiver requested (waiver form due 30 days prior to date of license expiration). Training Program exemption

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

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

Signature Virginia Siegfried

Date: 7.15.97



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.

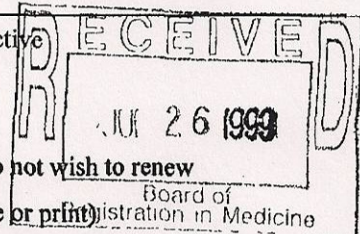
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

- 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.: 81013 Renewal Date: 09/22/1999

1. Current Status: Inactive



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:

Please make corrections (type or print)

3. A) Mailing/Business Address:
VIRGINIA ANN SIEGFRIED

Other Name(s): _____

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

B) Home Address: _____

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

Home Phone: _____
 Business Phone: _____

Home: (____) _____
 Business: (____) _____
 Date of Birth: (M/D/Y): ___/___/___ Sex: M F
 SS#: _____

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

5. A) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons

Full Name of Medical School: _____

B) Year Graduated: 1979 C) Degree: M.D.

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

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

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

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

Code: OG Code: _____

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

Federal (DEA): _____
 Mass: _____

9. A) Other states where you are now licensed to practice
 Abbr: CA NH
 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: SIEGFRIED Registration Number: 81013

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: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: ___ / ___ (AP) ___ % 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 Mutual of Maine Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

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

Please explain exemption: _____

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

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

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

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

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

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

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
inactive 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: Virginia Siegfried Date: 7/16/99

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



Commonwealth of Massachusetts Board of Registration in Medicine

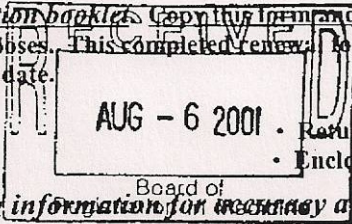
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

http://www.massmedboard.org

Physician Registration Renewal Application

1111010002

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



- Remit \$250.00 for renewal fee.
Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
Enclose check with coupon in BLUE envelope.

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

1. Current Status: Inactive Registration No.: 81013 Renewal Date: 09/22/2001

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

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

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

Please make corrections (type or print)

Other Name(s):
Mailing Address: 15 Old Rollinsford Rd #201
City/Town: Dover State: NH
Zip: 03820 Country:
Business Address: same as
City/Town: State:
Zip: Country:
Business Telephone: (603) 749-4963
Home Address:
City/Town: State: NH
Zip: Country:
Home Telephone:
PLEASE NOTE: No P.O. Box addresses for home or business addresses.

3. A) Mailing/Business Address: Virginia Ann Siegfried

B) Home Address:

Home Phone:

Business Phone: (603)772-1776

4. a) Date of Birth: b) Sex: F
c) SS#:
5. a) Name of Medical School:
b) Columbia Univ. College of Physicians & Surgeons
Year Graduated: 1979 c) Degree: M.D.
6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass.
OBG 0 Obstetrics and Gynecology
0

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: Code:
8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:
9. a) Other states where you are now licensed to practice (Abbr.)
CA-NH
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: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s): Wentworth-Douglass Hospital, Exeter Hospital

PRINT YOUR LAST NAME: SIEGFRIED LICENSE NUMBER: 81013

11. My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit
Name of Insurer: Kilbride & Harris 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) 20

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

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

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

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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) <input checked="" type="checkbox"/> CME exemption | | |

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

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: *Jaymie Alcott*

Date: 8/1/01

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

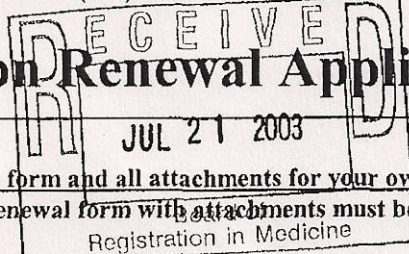
Board Regulations require that you notify the Board, in writing, of any change of address

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



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

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: Inactive Registration No.: 81013 Renewal Date: 09/22/2003

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

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

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

A) Mailing/Business Address:

3. Virginia Ann Siegfried
 15 Old Rollinsford Road
 #201
 Dover, NH 03820

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

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

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

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

4. a) Date of Birth: _____ b) Sex: **F**
 c) SS#: _____

5. a) Name of Medical School:
 Columbia Univ. College of Physicians & Surgeons
 b) Year Graduated: 1979 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.)
 _____ CA NH
 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: 999 ✓ (AP) 100 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
 Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
 If 999, print name(s): Wentworth Truist Hospital Dover NH

PRINT YOUR LAST NAME: SIEGFRIED LICENSE NUMBER: 81013

11. My medical malpractice insurance is covered by Insurance Carrier Letter of Credit
Insurer's name. (Required): _____ Policy dates: From: ___/___/___ To: ___/___/___

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

12. What is your principal work setting? (See Table 4) 20 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 0 hrs/wk B) outpatient care 0 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? _____%

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

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

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? Yes No
 CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.
CME EXEMPTION: Check one: Inactive status Residency/Fellowship training (See instructions).

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

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

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

Signature: *Summa Megala* Date: 7/16/03

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: Virginia Ann Siegfroid

License No.: 81013

PART A

1) Current Status: Inactive

Renewal Due Date: 08/25/2005

Birth Date:

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

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

15 Old Rollinsford Road
#201
Dover, NH 03820

Check here to change this address

2b) HOME ADDRESS

Phone:

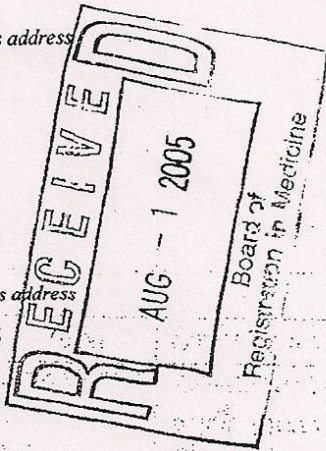
Check here to change this address

2c) BUSINESS ADDRESS

15 Old Rollinsford Road
#201
Dover, NH 03820

Phone: (603)749-4963

Check here to change this address



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

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

Home address cannot be a Post Office Box

Business Address: 24 Pennacook St
City/Town: Manchester State: NH
Zip: 03104 Country: USA
Business Telephone: (603) 624-1191

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

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

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty	Correct? Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>
			<input type="checkbox"/> <input type="checkbox"/>

08/01/05 82 187

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfroid

License No.: 81013

02/01/05 82

188

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

9) What is your principal work setting? (See Renewal Instructions, page 4.)

Principal Work Setting: Partnership or Group Practice Change to: clinic

Please enter the *approximate* number of work hours at your principal work setting: 8

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		Approximate # Hours per Week
		Current	Change	
Other	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: _____ hrs/wk

b) outpatient care 0 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: NHMMJUA Change to: _____

Policy dates: From / / To / / tail coverage as of 6/22/05

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): _____

→ Covered in clinic by Natl. Union 12/31/04 - 12/31/05 # 6793280

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfroid

License No.: 81013

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

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

Signature: _____

Virginia Ann Siegfroid

Date: _____

7.27.05

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

08-01-05 22 151

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfried, M.D.

License No.: 81013

08/20/07 81

PART A

1) Current Status: Inactive

Renewal Due Date: 08/25/2007

Birth Date:

If you want to change your current status, please check one of the following boxes to indicate your new status:

Check only one: (See Renewal Instructions, page 3.)

- Active
 Retiring
 Inactive
 Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

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

Check here to change this address

2b) HOME ADDRESS

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

RECEIVED
 AUG 17 2007
 Board of Registration
 in Medicine

Phone: _____

Check here to change this address

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

24 Pennacook Street
 Manchester, NH 03104

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

Phone: (603)624-1191

Check here to change this address

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

Correct your E-mail and Fax Number below:

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

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

List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfried, M.D.

License No.: 81013

02/20/07 51 93

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

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: _____ hrs/wk

b) outpatient care 0 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: National Union Fire Ins Co of Pittsburgh Change to: _____

Policy dates: From 12/31/05 To 1/1/08

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

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

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfried, M.D.

License No.: 81013

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

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

YES NO

14) CLAIMS MADE a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above). b) PENDING: Are there any unresolved malpractice claims against you today , i.e., any claims that have not been finally settled or finally adjudicated?
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? Yes No
b) If no, are you requesting a CME waiver? Yes No

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Virginia Ann Siegfried, M.D.

License No.: 81013

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

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

Signature: _____

Virginia Ann Siegfried

Date: _____

8/13/07

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

08/20/07 5:11 PM