DR
6/5/01
Ck# 149556

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JUN 5 2001
BOARD OF REGISTRATION IN MEDICINE

REDACTED COPY

Application #: 212150
Date Approved: 6/21/01

Commonwealth of Massachusetts- Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111 - www.massmedboard.org

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

- [x] Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- [ ] Graduate of an International Medical School (IMG)
- [ ] Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) Kouril (First) Margaret (MI) A

1-B. Other Name(s): _____

1-C. Mother's Maiden Name: Harmon

	YES	NO
1) Have you ever been known under a different name or combination of names?		
2) Have you ever been licensed under a different name?		
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?		

If you answer yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number _____

City: _____ State: _____ Zip: _____

3. Date of Birth: ____ ____ ____ (Month (Day) (Year)) Place of Birth: New York

4. Sex: [ ] Male [ ] Female 5. Social Security Number: ____ ____ - ____

6. Name of Massachusetts Training Hospital: Lawrence General Hospital

_____

(Street Address) (City)

PRINT NAME Margaret A. Kouril

7. Name of premedical school(s): Wesleyan University

Location: Middletown, CT USA
(City, State, Country)

8. Name of medical school(s): University of Texas Health Science Center

Location: San Antonio, TX USA
(City, State, Country)

Date of Graduation: 05/26/01 Degree: ☑ M. D. ☐ D. O. Other(specify)_____
(Month) (Day) (Year)

9. Have you had previous post-graduate training? ☑ No ☐ Yes ☐ U.S. or ☐ International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you *currently* have a license to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or training license (L).

____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

11. List states (abbreviations) where you were <u>previously</u> licensed to practice medicine (include residency-training licenses). Indicate whether full license (F) or residency or limited license (L).

____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

	YES	NO
12-A. If you are a USMG, have you taken more than <u>4 years</u> to complete medical school?	☐	☑
12-B. If you are an IMG, have you taken more than <u>6 years</u> to complete medical school? If yes, you must provide additional information. (See instructions).	☐	☐
13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? If yes, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)	☐	☑

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 Margaret A. Kayril (Name of Applicant) has been appointed

to the position of ☒ Intern ☐ Resident ☐ Fellow

in the specialty of Family Medicine as a PGY 1

Department: Residency Subspeciality:

at Greater Lawrence Family Health Center / Lawrence General Hosp. (Name of Healthcare Facility)

beginning 6 / 18 / 01 (Month) (Day) (Year) to anticipated completion of training: 6 / 28 / 04 (Month) (Day) (Year)

	YES	NO
1. Is the program accredited by the ACGME?	☒	☐
2. If **no**, is there an ACGME-approved training program in the applicant's specialty?	☐	☐
3. Have you reviewed Sections A and C of the limited license application?	☐	☐

Designated Official's Signature: X

Type or Print Name: Scott Early, MD.

Official Title: Program Director

Date: 5 / 16 / 01 Telephone Number: (978) 725-7410

SECTION C: PAGES 4-6 MUST BE COMPLETED BY APPLICANT

LIMITED LICENSE APPLICANT

Commonwealth of Massachusetts Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Margaret Kouril Date of Birth _ _ _

Print or Type Name: Kouril (Last name) Margaret (First Name) A (Middle Initial) Social Security No: _____

Other Name(s) _____ (Please type or print name(s))

Name of Medical School: University of Texas Health Science Center at San Antonio

Address: Floyd Curl Dr. City: San Antonio State or Province: TX 78229

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) to the applicant. Please sign or stamp across the seal on the envelope.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

Premedical Education: Does your school have a premedical school education requirement? ☐ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Continued on page 2

LIMITED LICENSE APPLICANT

Enrollment and Participation: Our records indicate that

KOURIL (Last name) MARGARET (First name) A (Middle initial)

(type or print the applicant's name):

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 11 / 97	05 / 22 / 98	06 / 26 / 00	12 / 24 / 00
	07 / 20 / 98	05 / 07 / 99	01 / 16 / 01	05 / 04 / 01
	06 / 16 / 99	06 / 17 / 00	/ /	/ /

The applicant attended 168 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one [X] WILL BE awarded a degree in DOCTOR OF MEDICINE on (month/day/year) 05 / 26 / 01

[ ] was NOT awarded degree. Please explain reason(s).

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A *TRANSCRIPT OR PROVIDE AN EXPLANATION.*

Signature: Leonard E. Lawrence, MD for LEL

Print Name: LEONARD E. LAWRENCE, M.D.

Title: ASSOCIATE DEAN FOR STUDENT AFFAIRS

Date: 05 / 16 / 01 Telephone: (210) 567-2665

This form will not be accepted unless it is stamped with the institutional seal or notarized.

FEB 17 2004

Application #: 220361
Date of Issue: _____

Commonwealth of Massachusetts - Board of Registration in Medicine
560 Harrison Avenue, Suite #G4, Boston, MA 02118 (617) 654-9810 - www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts.

Check One: ☑ U.S./Canadian Graduate ☐ International Graduate

Legal Name *(do not use nicknames or initials, unless they are part of your legal name)*

Kini | Margaret | Alice Kouril | _____
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree _____ ☐ Male ☑ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Kouril | Margaret | Alice | _____
Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: New Hyde Park | New York
City | State/Province/Territory | Country if not USA

Home Address: _____ _____
Number and Street

_____ _____ _____
City | State/Province/Territory | Zip (or postal) Code

Business Address: 34 Haverhill St.
Number and Street

Lawrence | MA | 01841
City | State/Province/Territory | Zip (or postal) Code

Business Telephone: (978)686-0090, ext. 456 Home Telephone:

Preferred Mailing Address: ☐ Business Address ☑ Home Address

Ck #1081
pd. $600
RF, 2-19-04

PRINT NAME: Margaret Alice Kouril Kini PAGE 2 OF 3

Pre-medical School

			From	To
Facility: Wesleyan University	Degree: B.A.		09/01/1990	06/30/1994
Street: _____	City: Middletown	State: CT		
Facility: _____	Degree: _____		__/__/__	__/__/____
Street: _____	City: _____	State: _____		

Medical School

			From	To
Facility: Univ. of Texas at San Antonio	Degree: M.D.		08/01/1997	05/26/2001
Street: Floyd Curl Drive	City: San Antonio	State: TX		
Facility: _____	Degree: _____		__/__/__	__/__/____
Street: _____	City: _____	State: _____		

Date of medical school graduation: 05/26/2001

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

				From	To
Facility: Greater Lawrence Family Practice	Position: Residency PGY1-3			07/01/2001	06/30/2004
Street: Haverhill Street	City: Lawrence	State: MA			
Facility: _____	Position: _____			__/__/__	__/__/__
Street: _____	City: _____	State: _____			
Facility: _____	Position: _____			__/__/__	__/__/__
Street: _____	City: _____	State: _____			
Facility: _____	Position: _____			__/__/__	__/__/__
Street: _____	City: _____	State: _____			
Facility: _____	Position: _____			__/__/__	__/__/____
Street: _____	City: _____	State: _____			

2004 FEB 24 PM 12:03

Margaret Kouril Kini

PRINT NAME: Margaret Alice Kauril Kini PAGE 3 OF 3

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		

1. List other states (abbreviations) where you are currently or have ever been licensed: _____ _____ _____
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☑ No
3. List Board Certification(s): _____ Certification date: __/__/__

   _____ Certification date: __/__/__
4. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Fellowship at Greater Lawrence Family Health Center
6. Name of Facility: Greater Lawrence Family Health Center
7. Address: 34 Haverhill St City: Lawrence
8. Anticipated starting date in Massachusetts: 08/01/2004

Affidavit of Applicant

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

Margaret Kini
Signature of Applicant

2/8/04
Date

Rev: 10/21/2002

Enrollment and Participation: Our records indicate that

Medical Education Verification - 2

KINI	KOURIL	MARGARET	A.
(type or print the applicant's name): (Last name)		(First name)	(Middle initial)

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/04/97	05/22/98	07/20/98	05/07/99
	06/16/99	06/17/00	06/26/00	12/24/00
	01/16/01	05/04/01	/ /	/ /

The applicant attended 42 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one ☒ was awarded a degree in MEDICINE on (month/day/year) 05/26/2001

☐ was NOT awarded degree. Please explain reason(s).

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS:

AFFIX INSTITUTIONAL SEAL HERE

(if the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature:

Print Name: LEONARD E. LAWRENCE, M.D.

Title: ASSOC. DEAN FOR STUDENT AFFAIRS

Date: 03/19/2004 Telephone: (210) 567-4429

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Seal Verified

DATE: 3-25-04

INITIALS: RF

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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Margaret Kini Date: 2/8/04

Print or Type Name: Margaret Kini

Name of Institution: Greater Lawrence Family Practice Residency

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Lawrence Family Practice Residency

If name of Institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Margaret Kini participated in the following program:
(Print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	Family Practice	6/18/01	6/28/02	Yes	ACGME
Residency	2	Family Practice	6/29/02	6/27/03	Yes	ACGME
Residency	3	Family Practice	6/28/03	6/24/04	anticipated	ACGME

(Continued on page 2)

APPLICANT'S NAME: Margaret Kini

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☑ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: Dr Kowil is a truly stellar resident!

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: X [signature]

Print Name: Scott Early, MD

Academic Title: Residency Program Director

Telephone: (978) 725-7410 Today's Date: 2/12/04

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified

DATE: 2-19-04

INITIALS: RF

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini **License No.:** 220361

PART A

1) Current Status: Active **Renewal Due Date:** 03/04/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

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

34 Haverhill Street
Lawrence, MA 01841

Phone: (978)686-0090 Ext. 456

☐ *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: _____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Family Practice	☐	
	☐	
	☐	

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?**
Family Practice	☒	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini **License No.: 220361**

(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:	___ ___ ___ ___ ___ ___ ___ ___
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	___ ___ ___ ___ ___ ___ ___ ___

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

Principal Work Setting: Clinic Change to: _____

Please enter principal work setting hours per week here: 60

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 ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	# Hours per Week
Greater Lawrence Health Center	☐	Active		60
	☐	in Fellowship		
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ____ hrs/wk

b) outpatient care 30 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: FTCA Change to: _____

Policy dates: From 09/01/04 To 04/01/07
(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: Margaret A Kini **License No.: 220361**

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*

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini **License No.: 220361**

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: Margaret Kini Date: 2/4/05

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

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.:** 220361

PART A

1) Current Status: Active **Renewal Due Date:** 03/04/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

☑ *Check here to change this address*

RECEIVED
FEB 28 2007
Board of Registration in Medicine

Please make corrections (print)

Mailing Addres
City/Town: State:
Zip: Country:

2b) HOME ADDRESS

Phone:

☑ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
34 Haverhill Street
Lawrence, MA 01841

Phone: (978)686-0090 Ext. 456

☐ *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:

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Family Practice	☐	Obstetric Fellowship Trained
	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.: 220361**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

___ ___ ___ ___ ___ ___ ___

9) States where you were previously licensed

___ ___ ___ ___ ___ ___ ___

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Greater Lawrence Family Health Center	Lawrence, MA	MA	☐
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: 20 hrs/wk

b) outpatient care 30 hrs/wk Change to: 20 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: Federal Tort Claims Act Change to: _____

Policy dates: From 4/01/06 To 3/31/07

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: Margaret A Kini, M.D. **License No.: 220361**

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: Margaret A Kini, M.D. **License No.: 220361**

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: Margaret Kini Date: 2/20/07

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

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane MD

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.: 220361**

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.
Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

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

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

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

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

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

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

☒ My current NPI is: 1942287065

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207Q00000X	Family Practice
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

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

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.

Signature: Margaret Kini Date: 2/21/07

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 OTHER PURPOSES.

FREQUENTLY ASKED QUESTIONS
REGARDING OFFICE BASED SURGERY- FORM PCA-O

Question #1:
"If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?"

Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form it its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org

Question #2:
"I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?"

The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org

Question #3:
"If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?"

You only have to fill out the form if you perform office-based procedures in Massachusetts.

Question #4:
"I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?"

No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.

Question #5
"I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?"

You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.

Mass.Gov • online services • agencies • elected officials • help

Back | Home | How to Read a Profile

Massachusetts Board of Registration in Medicine Physician Profile

Margaret A. Kini, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status:	**Active**
License Issue Date:	5/5/2004
Accepting New Patients:	No
Accepts Medicaid:	No Yes.
Primary Work Setting:	Clinic
Business Address:	34 Haverhill Street Lawrence, MA 01841
Phone:	(978) 686-0090 Ext.456
Translation Services Available:	None Reported Yes.
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	Greater Lawrence Family Health Center (Active)

II. Education & Training

Medical School:	University of Texas Medical School, San Antonio
Graduation Date:	2001
Post Graduate Training:	None Reported Lawrence Family Medicine Residency. Lawrence Obstetrics Fellowship.

III. Specialty

Area of Specialty:	Family Practice

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Practice	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Kini has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Kini has had no criminal convictions in the past ten years.

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Kini has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Kini has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 617-654-9830
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.: 220361**

03/04/09 S1 531

PART A

1) Current Status: Active **Renewal Due Date:** 03/04/2009 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

RECEIVED
MAR 3 2009
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
34 Haverhill Street
Lawrence, MA 01841

Phone: (978)686-0090 Ext. 456

☑ *Check here to change this address*

Business Address: 4613 Oakmont Blvd
City/Town: Austin State: TX
Zip: 78731 Country: _____
Business Telephone: (210) 887-8726

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:**
Family Medicine	☐	
	☐	
	☐	

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?**
Family Medicine	ABMS	Family Medicine	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.: 220361**

03/04/09 S1 532

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

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	**Location (City or Town)**	**State**	**Delete?**
			☐
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: 0 hrs/wk

b) outpatient care 20 hrs/wk Change to: 0 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: Federal Tort Claims Act Change to: _____

Policy dates: From ___/___/___ To ___/___/___

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: Margaret A Kini, M.D. **License No.: 220361**

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: Margaret A Kini, M.D. **License No.: 220361**

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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: Margaret Kini Date: 2/20/09

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.

Mass.Gov [redacted]

• online services • agencies • elected officials [redacted]

Massachusetts Board of Registration in Medicine Physician Profile

Margaret A. Kini, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status:	**Active**
License Issue Date:	5/5/2004
Accepting New Patients:	No
Accepts Medicaid:	No
Primary Work Setting:	Clinic
Business Address:	~~34 Haverhill Street~~ ~~Lawrence, MA 01841~~
Phone:	~~(978) 686-0090 Ext.456~~
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	None Reported

II. Education & Training

Medical School:	University of Texas Medical School, San Antonio
Graduation Date:	2001
Post Graduate Training:	None Reported

III. Specialty

Area of Specialty:	Family Medicine

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Medicine	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Kini has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Kini has had no criminal convictions in the past ten years.

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Kini has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Kini has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 781-876-8230
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Phone 781-876-8200
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Margaret A Kini, M.D. **License No.:** 220361

Current Status: Active **License Expiration Date:** 4/1/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
311 Le Grande Ave
Austin
Texas - 78704
United States of America

Home Address:

Business Address:
311 Le Grande Ave
Austin
Texas - 78704
United States of America
(210) 887-8726

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
Texas

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
	None Reported

Physician Name: Margaret A Kini, M.D. **License No.:** 220361

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 32 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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

14) Claims Made
a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
d) Are any Application of Issuance of Process pending against you?

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?

20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?

21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Physician Name: Margaret A Kini, M.D. **License No.:** 220361

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

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

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

Physician Name: Margaret A Kini, M.D. **License No.:** 220361

Compliance with Legal Responsibilities

Online profile:
☒ I have reviewed my Profile and I will contact the Board for assistance with certain information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Kouril, Margaret

Medical Education

University of Texas Medical School at San Antonio, San Antonio, TX
08/1997 - 05/2001
Medical Degree, 05/2001

Undergraduate Education

Wesleyan University, Middletown, CT
09/1990 - 05/1994
Bachelor of Arts, Women's Studies

Employment

09/1987 - 05/1994
The Learning Center, Glen Cove, NY
Tutor and Program Assistant
Designed lessons and taught students with learning disabilities under the supervision of a certified L.D. teacher. Expanded this small home-run business by training other tutors. Designed additional workspace and created a computerized billing system. Obtained state certification in Identification and Reporting of Child Abuse and Maltreatment.

06/1991 - 08/1991
CA Rich Consultants, Inc., Sea Cliff, NY
Environmental Field Assistant
Performed environmental fieldwork, prepared reports, and researched commercial properties under investigation for contaminated soil and groundwater.

06/1994 - 09/1994
Fremont Public Association, Seattle, WA
Home Care Community Aide
Provided social services, personal care and emotional support during home visits to people and families living with AIDS.

10/1994 - 08/1995
SHIPS Tutoring Program, Austin, TX
Tutor and Special Education Director
Created and implemented academic support programs for students with learning disabilities as part of a start-up program created by a pediatrician.

Employment

12/1994 - 05/1996
Reproductive Services of Austin
Family Planning Clinic Coordinator
Directed and reorganized the counseling program and triage area. Trained and supervised six staff members. Provided clients with decision counseling, education, and resources regarding options for an unplanned pregnancy and family planning. Supervised inventory, scheduling, reception of clients, and Department of Health statistics. Developed proficiency in all areas of the clinic, including lab, procedure room, and recovery room as a medical assistant.

05/1996 - 08/1997
Fred Hansen, M.D., Austin, TX
Ob/Gyn Clinical Assistant
Evaluated and monitored patients and assisted physician during procedures.

09/1996 - 06/1997
Huntington-Surrey School, Austin, TX
High School Teacher
Taught mathematics. Developed and taught self-defense elective course.

08/2000 - 09/2000
University of Texas Medical School at San Antonio
Teaching Assistant - Male Reproductive Lab
Trained second year students to perform male genital and prostate exams and to become comfortable taking urologic history.

Research Experience

09/1993 - 05/1994
Wesleyan University
Undergraduate student
Senior Research Honors Project: Analyzed midwifery legislation and practice in the states of New York, Connecticut, and Texas.

Publications

Urology, In Press.
The Prostate Cancer Prevention Trial: Current Status and Lessons Learned.
Thompson IM, Kouril M, Klein E, Coltman CA, Ryan A, Goodman P, et al.
Volume: , Pages:

Volunteer Experience

09/1991 - 05/1992
Wesleyan University
Sexual Assault Educator
Facilitated student workshops about sexual assault issues and awareness.

Volunteer Experience

09/1991 - 05/1994
Women's Collective and Health Education Collective
Volunteer and Member, Wesleyan University
Organized and publicized events, recruited speakers, maintained and updated resources for the Women’s Center and the Health Education Center.

06/1993 - 01/1994
Women's Studies Department of Wesleyan University
Apprentice to Midwife
Shadowed a midwife during prenatal, postpartum and birthing visits.

08/1993 - 08/1994
Wesleyan University
Self-Defense Teacher
Founded women’s self-defense program, taught classes and trained other instructors.

09/1994 - 09/1995
Planned Parenthood
Health Educator
Organized and presented educational workshops to women in the community about HIV/STDs, reproductive health, and family planning.

05/1995 - 05/1996
Ceden
Prenatal Educator
Provided social services and education to pregnant teenagers during home visits.

09/1995 - 08/1997
Habitat for Humanity
Volunteer
Helped build simple, affordable houses in partnership with people in need of shelter.

06/1997 - 08/1997
Casa Clinica, Las Varas, Mexico
International Medical Volunteer
Evaluated and treated uninsured patients in Casa Clinica while participating in a Spanish immersion program. Helped build houses in a village with Techos de Mexico.

06/2000 - 07/2000
South Texas Environmental Education and Research
Public Health Volunteer
Helped physicians, biologists, and public health workers develop, implement and evaluate strategies concerning U.S.-Mexico border health care issues such as sanitation, infectious disease, and antibiotic resistance.

Licensure

USMLE Step 1 *06/1999*

Language Fluency (Other than English)

Conversational Spanish

Other Accomplishments

Awarded Johnston Trust Scholarship (1991) and Kiwanis Scholarship (1991) based on academic excellence and dedication to extracurricular activities. Awarded Dana Grant (1993) based on dedication to women's issues.

Hobbies & Interests

Swing, latin, and ballroom dancing, traveling, tennis, swimming, and hiking.

MARGARET KOURIL KINI

EDUCATION

Family Practice Residency: Greater Lawrence Family Health Center	2001-2004
M.D. The University of Texas Health Sciences Center at San Antonio	1997-2001
B.A. Wesleyan University, Middletown, CT (Major: Women's Studies)	1990-1994

RESIDENCY PROGRAM

Community-based primary care health clinic with several sites. Strong sense of mission to effectively meet the needs of underserved Latino population of the city of Lawrence.

Emphasis on hospital skills, including strong obstetrics training, in addition to development of effective outpatient clinical skills. Most graduates work in underserved areas in US or abroad.

Spanish language instruction part of curriculum. Majority of patient care is in Spanish.

Community medicine project with longitudinal work on women's empowerment, particularly focused on reproductive health. Included research project and development of new protocols for clinical care adapted throughout the clinic system.

Taught prenatal classes in Spanish as part of class project.

PUBLICATIONS & RESEARCH

Thompson IM, Kouril M, Klein E, Coltman CA, Ryan A, Goodman P et al. *The Prostate Cancer Prevention Trial: Current Status and Lessons Learned.* Urology, In Press.

Senior Research Honors Project: *Midwifery Legislation*, Wesleyan University 1993-1994

PRE-MED COMMUNITY HEALTH CARE EXPERIENCE

OB/Gyn Clinical Assistant, Fred Hansen, M.D., Austin, TX	1996-1997
Family Planning Clinic Asst Coordinator, Reproductive Services, Austin, TX	1994-1996
Pre-Natal Teen Home Visit Educator, Ceden, Austin, TX	1995-1996
Health Educator, Planned Parenthood, Austin, TX	1994-1996
AIDS Home Care Aide, Fremont Public Association, Seattle, WA	Summer 1994
Apprentice to Midwife, Glen Cove, NY	Summer 1993
Environmental Consulting Agency Field Assistant, CA Rich Consultants, NY	Summer 1991

TEACHING EXPERIENCE

Teaching Assistant, Male Reproductive Lab, UTHSCSA	Fall 2000
High School Teacher, Huntington-Surrey School, Austin, TX	1996-1997
Tutor and Special Education Director, SHIPS Tutoring Program, Austin, TX	1994-1995
Self-Defense Teacher, Wesleyan University	1993-1994
Tutor and Program Assistant, The Learning Center, Glen Head, NY	1987-1994

EXTRACURRICULAR ACTIVITIES

STEER Border Health Care Volunteer, Laredo, TX	Summer 2000
International Medical Volunteer at Casa Clinica, Las Varas, Mexico	Summer 1997
Sexual Assault Educator, Wesleyan University	1991-1992
Women's Health Education Collective Speaker Organizer, Wesleyan Univ.	1991-1994

AWARDS & SCHOLARSHIPS

Johnston Trust Scholarship (based on academics and extracurricular)	1990-1991
Kiwanis Scholarship (based on academics and extracurricular)	1990-1991
Dana Grant (based on dedication to women's issues)	1993-1994

MEDICAL CERTIFICATIONS & COURSES

Advanced Life Support in Obstetrics,
Neonatal Resuscitation Program,
Advanced Cardiac Life Support,
Basic Life Support,
Fundamentals of Critical Care,
AAFP Family Centered Maternity Care

Language: Spanish