pd 5/17/00
$50
CK#1089

Application #: 207151
Date Approved: 5/24/00

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111

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) Cleveland (First) Byrd (MI) ____

1-B. Other Name(s): Laura Elizabeth Cleveland

1-C. Mother's Maiden Name: _____ _____ Social Security No.

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

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

2. Current Residence: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

3. Date of Birth: _____ _____ _____ Place of Birth: Denver Colorado
(Month) (Day) (Year)

4. Sex: [ ] Male [x] Female 5. Social Security Number: _____

6. Name of Massachusetts Training Hospital: MetroWest Medical Center
Framingham Union Hospital 115 Lincoln Street
(Street Address) (City)
Framingham MA 01701-9167

NAME: Byrd Cleveland

7. Name of premedical school(s): University of Texas, Austin Tx USA
Location: University of Pittsburg Pa, Pittsburgh PA, USA
(City, State, Country)

8. Name of medical school(s): New York Medical College
Location: Valhalla NY USA
(City, State, Country)
Date of Graduation: 05 / 19 / 2000 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 are currently licensed to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or limited license (L).
Ø ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

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

	YES	NO
12-A. If you are a USMG, have you taken more than 4 years to complete medical school?	☐	☑
12-B. If you are an IMG, have you taken more than 6 years 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.)	☐	☑

NAME: Byrd Cleveland

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

This certifies that BYRD CLEVELAND, M.D. (Name of Applicant) has been appointed

to the position of [X] Intern [ ] Resident [ ] Fellow

in the specialty of TRANSITIONAL YEAR PROGRAM as a PGY ONE

Department: _____ Subspeciality: _____

at METROWEST MEDICAL CENTER-FRAMINGHAM UNION HOSPITAL (Name of Healthcare Facility)

beginning 6 / 24 / 00 (Month) (Day) (Year) to anticipated completion of training: 6 / 24 / 01 (Month) (Day) (Year).

	YES	NO
Is the program accredited by the ACGME?	[X]	[ ]
If **no**, is there an ACGME-approved training program in the applicant's specialty?	[ ]	[ ]

Designated Official's Signature: Joel L. Bass, M.D.

Type or Print Name: JOEL L. BASS, M.D.

Official Title: DIRECTOR, TRANSITIONAL YEAR PROGRAM

Date: 4 / 25 / 00 Telephone Number: 508-383-1555

NAME: Byrd Cleveland

	YES	NO
14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).		

Explanation attached: ☐ Program Director's explanation requested: ☐

If you answered "yes" to question 14, a letter from your program director is required.

SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.

	YES	NO
15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?		
16-A. Have you ever been terminated by a medical school or postgraduate training program?		
16-B. Have you ever been granted a leave of absence by a medical school or a postgraduate training program?		
16-C. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?		

If you answered "yes" to 16-A,B or C, a letter from your medical school(s) or postgraduate training program(s) is required.

17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?		
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		

NAME: Byrd Cleveland

YES NO

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you ever voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

26. Have you ever been charged with any criminal offense, other than a minor traffic offense?

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

28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. In the past ten (10) years, 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 has such a suit been settled, adjudicated or otherwise resolved?

NAME: Byrd Cleveland

CONFIDENTIAL MEDICAL INFORMATION

Before completing the following questions, refer to the instructions for definitions and additional information. If answering "yes" to any of the questions, you must provide details on the Limited License Supplement. For purposes of the following questions, "currently" does not mean on the day of, or even the weeks or months preceding the completion of this application. It means recently enough to have an impact on one's functioning as a licensee, or within the past two years.

		YES	NO
30.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician?		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician?		
32.	Within the past two years, have you engaged in the use of chemical substances with the result that your ability to practice medicine is currently limited or impaired?		
33.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of chemical substances?		
34.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
35.	Within the past five years, have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

If your responses to Questions 15-35 change while your application is pending, you must notify the Board of the new information immediately. Please note that your license expires at the end of the academic year and must be renewed. A limited licensee may practice medicine only at the institution or its affiliates. With a limited license you are not allowed to "moonlight" under any circumstances.

CERTIFICATIONS:

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

Pursuant to M.G.L. c. 119, § 51A, I certify under the penalties of perjury that I will fulfill my obligation to report abuse or neglect of children. I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I certify under the penalties of perjury that all information on this form (front and back, and all attached pages) is true, to the best of my knowledge

Applicant's Signature: Byrd Cleveland **Date:** 4/17/00