REDACTED COPY

Application #: 239110
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 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. The application fee is non-refundable.

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

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

Roncari Danielle Marie
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 ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ Social Security Number: ___ - ___ - ___
Month Day Year

Place of Birth: Newton MA
City State/Province/Territory Country if not USA

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone _____
Number and Street

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

Business Address: _____ Telephone: _____
Number and Street

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

E-mail Address: _____ Fax number: _____

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

*** The Board will use your Mailing Address for all correspondence**

CK. # 784
02/03/09
WS

RECEIVED
FEB 12 2009
Board of Registration in Medicine

04/02/09 S1 611

PRINT NAME: Danielle Roncari

Pre-medical School

Facility: Columbia College Columbia University Degree: BA From 08/1/93 To 05/1/97
Street: 2960 Broadway City: New York State: NY

Facility: Goucher College Degree: ____ 05/1/99 05/1/00
Street: 1021 Dulaney Valley Rd City: Towson State: MD

Medical School

Facility: Leonard Miller SOM Degree: M.D. From 08/10/01 To 05/14/05
Street: 1600 NW 10th Avenue City: Miami State: FL

Facility: _____ Degree: ____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 05/14/05
Month Day Year

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: Tufts Medical Center Position: Resident 06/28/05 __/__/__ current
Street: 800 Washington St City: Boston State: MA

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

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

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

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

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I	6/18/03	☒ P	☐ F	1
USMLE Step II	11/5/04	☒ P	☐ F	1
USMLE Step III	5/2/06	☒ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

PRINT NAME: Danielle Roncari

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 had a full license: PA

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): _____ Certification date: __/__/__

   _____ Certification date: __/__/__

4. List your practice specialt(ies) OB/GYN

5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: Family Planning Fellow to start 7/2009 at Boston Medical Center

7. Name of Facility: Boston Medical Center
   Address: Harrison Ave City: Boston

8. Anticipated starting date in Massachusetts: 07/01/2009

Under the penalties of perjury, I declare that I have examined this full 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 a full 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 of Applicant

01/24/2008
Month Day Year

(Continued on page 5)

04/02/09 S1 85

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 full license application to be complete, 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. You must notify the Board once you have received your NPI Number. 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). You must notify the Board once you have received your NPI Number.

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

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

☒ My current NPI is: 1 3 9 6 8 6 5 8 7 9

☐ I have personally applied for an NPI.

☐ 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.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (Taxotomy codes are on following page of this license application and page 12 of Full License Application Instructions). 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:	2 0 7 V 0 0 0 0 0 X	Obstetrics & Gynecology
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): MA Country of Birth (if outside the 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

Check one box: ☒ I authorize ☐ I do not authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan or health organization.

_____ 11/24/08

Signature of Applicant Date

04/02/09 S1 75

SUPPLEMENT FORM

PRINT NAME: Danielle Roncari DATE: 11/24/08

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. 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).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: _____ Date: 11/24/08

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	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?		
9-C.	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?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	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?		
12.	Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	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?		
15-B.	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?		

Applicant's Signature: _____ **Date:** 11/24/06

Full License Application

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

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.

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: _____ Date of Birt.. _____

Print or Type Name: Roncuri (Last name) Danielle (First Name) M (Middle Initial) Social Security Nc _____

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

Name of Medical School: University of Miami School of Medicine

Address: 1600 NW 10 Avenue (A-128) City: Miami State or Province: FL

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) and mail it to the Board of Registration in Medicine.

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: COLUMBIA University

Undergraduate School Address: NEW YORK

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

(type or print the applicant's name):	(Last name)	(First name)	(Middle initial)
Roncari		Danielle	M

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/10/01	6/21/02	7/19/02	5/16/03
	7/7/03	6/15/04	6/21/04	5/13/05
	/ /	/ /	/ /	/ /

The applicant attended 166 **total weeks or** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

check one ☑ was awarded a degree in **DOCTOR OF MEDICINE** on (month/day/year) 05/14/2005

☐ 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: Ana Campo, M.D.

Title: Assistant Dean for Student Affairs

Date: 01/06/09 Telephone: (305) 243-3075

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

Seal Verified
DATE: 2/09
INITIALS: CH

RECEIVED
JAN 13 2009
Board of Registration in Medicine

LIMITED LICENSE APPLICANT

COMMONWEALTH OF MASSACHUSETTS, BOARD OF REGISTRATION IN MEDICINE
560 Harrison Avenue, Suite #G-4, Boston, Massachusetts 02118 - (617) 654-9810 www.massmedboard.org

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: _____ Date of Birth __

Print or Type Name: Ronceri (Last name) Danielle (First Name) M (Middle Initial) Social Security No: _____

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

Name of Medical School: University of Miami School of Medicine

Address: 1600 NW 10th Avenue City: Miami State or Province: FL

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: Columbia University

Undergraduate School Address: New York, NY

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MAY - 5 2009
BOARD OF REGISTRATION IN MEDICINE

Continued on page 2

Enrollment and Participation: Our records indicate that

KONCARI DANIELLE M LIMITED LICENSE APPLICANT

(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
08/19/01	06/10/02	06/21/04	05/14/05
07/14/02	05/12/03	/ /	/ /
07/07/03	06/26/04	/ /	/ /

The applicant attended 166 total weeks, or _____ total months of continuing on-campus education, not less than 32 weeks in each academic year

check one ☐ was awarded a degree in _____ on (month/day/year) ___/___/___

☑ will be awarded on 05/14/2005 ☐ was NOT awarded degree. Please explain in comments section.

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: Robert L. Hernandez, M.D.

Title: Associate Dean for Student Affairs

Date: 04/29/2005 Telephone: (305) 243-2013

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

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 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: _____ Date: 11/24/08

Print or Type Name: Danielle Marie Roncari

Name of Institution: Tufts Medical Center

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: Tufts Medical Center

If name of Institution was different when applicant attended, please enter name:
Tufts New England Medical Center

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

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	PGY 1	OB-Gyn	6-23-05	6-22-06	Yes	ACGME
Residency	PGY 2-3-4	OB-Gyn	6-23-06	Present	graduate 6-14-09	ACGME

(Continued on page 2)

APPLICANT'S NAME: Danielle Roncari

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:

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:

Print Name: David Chelmow MD

Academic Title: Residency Program Director

Telephone: (617)636-0265 Today's Date: 1/28/2009

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

Seal Verified

DATE: 2/09

INITIALS: CH

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

Waiver for Release of Information
I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.

Liability Carrier: Tufts Medical Center Indemnity Co From: 10 12005 To: 10 12009
City: Boston State: MA Policy Number: 2008TMCIC-2

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Liability Carrier: _____ From: ___/___ To: ___/___
City: _____ State: _____ Policy Number: _____

Applicant's signature: D Roncari 1/27/09
Date

Print Name: Danielle Roncari

Address: _____ City: _____

State: _____ Zip code: _____

Additional forms available at the Board's website at www.massmedboard.org

DA 5125105 488

Application #: 225872
Date Approved: 5/25/05

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

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form. Print or write legibly or type your answers. Please attach a $100.00 check payable to the Commonwealth of Massachusetts.

RECEIVED
MAY 13 2005
Board of Registration in Medicine

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) Roncari (First) Danielle (MI) M

1-B. Other Name(s): _____

	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 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: Newton, MA

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

6. Name of Massachusetts Training Hospital: New England Medical Center

750 Washington Street (Street Address) Boston (City)

PRINT NAME Danielle Roncari

7. Name of premedical school(s): Columbia College, Columbia University
Location: New York, NY USA
(City, State, Country)

8. Name of medical school(s): University of Miami
Location: Miami, FL USA
(City, State, Country)
Date of Graduation: 05/14/05 (Month) (Day) (Year) Degree: ☒ M. D. ☐ D. O. Other(specify)_____

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 *ever* had a license to practice medicine (include *residency* training licenses). Indicate whether full license (F) or residency or training license (L).
_____ ☐(Full) _____ ☐ (Full) _____ ☐ (Full) _____ ☐(Limited) ☐ (Limited)_____

11. Please indicate all the licensing examinations that you have have completed with a passing score:
USMLE ☒ Step 1 ☒ Step 2 ☐ Step 3 NBME ☐ Part 1 ☐ Part II ☐ Part III
FLEX ☐ Part 1 ☐ Part II ☐ COMLEX ☐ Level 1 ☐ Level 2 ☐ LMCC

	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.)	☐	☒

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 Danielle M Roncari, MD has been appointed
(Name of Applicant)

to the position of ☑ Intern ☐ Resident ☐ Fellow

in the specialty of Obstetrics + Gynecology as a PGY 1

Department: Obstetrics + Gynecology Subspeciality: —

at Tufts-New England Medical Center
(Name of Healthcare Facility)

beginning 6 / 23 / 05 to anticipated completion of training: 7 / 1 / 09
(Month) (Day) (Year) (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?	☑	☐

and

Designated Official's Signature: Deeb Salem MD

Type or Print Name: Deeb N. Salem, M.D.

Official Title: Chief Medical Officer

Date: 5 / 2 / 05 Telephone Number: (617) 636-5196

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

PRINT NAME: Danielle Ronsani

SECTION C: 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
14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).		
If you answered "yes" to question 14, you must provide an explanation and a letter from the program director is required.		
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?		

PRINT NAME: Danielle Roncari

		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?		

DANIELLE RONCARI

EDUCATION

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE — Miami, FL
Doctor of Medicine, May 2005 (anticipated)

GOUCHER COLLEGE — Baltimore, MD
Post-Baccalaureate Premedical Certification, May 1999

COLUMBIA COLLEGE, COLUMBIA UNIVERSITY — New York, NY
Bachelor of Arts, English Literature, May 1997

HONORS

- University of Miami School of Medicine Scholarship (2001 – 2005)
- Magna Cum Laude, Columbia University (May 1997)
- Charles Paterno Barratt-Brown Memorial Prize *for critical writing* (March 1997)
- Dean's List, Columbia University (1993-1997)

LICENSURE

- USMLE Step 1 – Pass, June 2003
- USMLE Step 2 CK – Pass, November 2004
- USMLE Step 2 CS – Pass, January 2005

PROFESSIONAL EXPERIENCE

PLANNED PARENTHOOD, SARASOTA, FL — 2000 – 2001
Clinic Assistant

- Assisted in all surgical procedures
- Obtained patient histories
- Counseled patients on contraception and pregnancy options

CB RICHARD ELLIS INTERNATIONAL CORPORATE ADVISORY GROUP — 1997 – 1999
Research Director / Associate

- Researched international office markets
- Prepared market reports and strategic studies for corporate clients
- Project management for US multinationals locating overseas

COLUMBIA UNIVERSITY SCHOOL OF SOCIAL WORK — 1996 – 1997
Student Services Assistant

DAVID NISINSON FINE ARTS — 1995 – 1996
Art Dealer Assistant

LOWELL NATIONAL HISTORICAL PARK — Summer 1995
National Park Ranger

RESEARCH AND PUBLICATIONS

- Roncari, D., Norris, P. Emergency Contraception – Knowledge and Perceptions. Abstract in Progress, 2004-5.
- Roncari, D. Planning a Regional Conference in a Hostile Environment. Poster presented at Medical Students for Choice National Meeting, New Orleans, April, 2004.
- Roncari, D., Eisermann, J. The use of the harmonic scalpel in ovarian cortical ablation for the treatment of polycystic ovarian disease. Abstract published in South Florida Institute for Reproductive Medicine, 2003
- Roncari, D. Curriculum Reform Looking Back. Medical Students for Choice Newsletter, October 2003.

VOLUNTEER AND COMMUNITY SERVICE

- Contraception Health Educator at Booker T. Washington High School, 2003
- Haiti Medical Trip, Medishare, 2002
- Little Haiti Health Fair Women's Health Co-Coordinator, 2002
- Contraception Information Booth Coordinator, Primary Care Health Week at JMH, 2002
- Florida Keys Pre-Registration Committee, 2003
- Florida Keys Health Fair Participant, 2002
- Sarasota Emergency Room Volunteer, 2000 – 2001
- Greater Baltimore Medical Cancer Center Volunteer, 1999 – 2000

ACADEMIC ACTIVITIES

- Medical Students for Choice
  - National Coordinator, Southeast Region, 2004 – current
  - Board of Directors, 2004 – current
  - Student Advisory Counsel, 2003 – current
  - Conference Coordinator, Southeastern Regional Conference ,Atlanta, GA, 2003 – 2004
  - Regional Coordinator, Region 10, 2003 – 2004
  - Student Coordinator, 2002 – 2003
- University of Miami Academic Societies – put a blurb in here about what this is....
  - Laennec Society Training Coordinator, 2004 – current
  - Laennec Society Certified Clinical Skills Instructor, 2003 – current
  - University of Miami Academic Societies Leadership Training Summit
- Student Government Representative, University of Miami Medical Women, 2002 – 2003

PROFESSIONAL ORGANIZATIONS

- American College of Obstetricians and Gynecologists, Medical student member, current
- American Medical Women Association - Member – current
- University of Miami Ob/Gyn Interest Group – Member - current

EXTRACURRICULAR ACTIVITIES

- Inlingua conversational Spanish lessons
- Columbia College Alumni Club
- Columbia College Alumni Representative Committee
- Miami Tropical Marathon, Miami, FL, February 2003
- Cooking
- Reading novels
- Scuba diving

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Danielle M Roncari, M.D. **License No.:** 239110

Current Status: Active **License Expiration Date:** 4/10/2010

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
850 Harrison Ave., YACC-4
RM 4S-39
Boston
Massachusetts - 02118
United States of America

Home Address:
850 Harrison Ave., YACC-4
RM 4S-39
Boston
Massachusetts - 02118
United States of America
(617) 414-3744

Business Address:
850 Harrison Ave., YACC-4
RM 4S-39
Boston
Massachusetts - 02118
United States of America
(617) 414-3744

3) Email Address:

4) Fax Number:

5) Specialties
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
None Reported			

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
None Reported

9) States where you were previously licensed
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
Boston Medical Center	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 30 hrs/wk
b) outpatient care 5 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Ctr Ins.	06/30/2009	06/30/2010	Claims made with tail coverage

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 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: Danielle M Roncari, M.D. **License No.:** 239110

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) Yes

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Danielle M Roncari, M.D. **License No.:** 239110

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

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

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

6) I understand and agree to comply with my obligations to report a 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.

[X] **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.**

[X] **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.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Danielle M Roncari, M.D. **License No.:** 239110

Current Status: Active **License Expiration Date:** 4/10/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Tufts Medical Center
800 Washington Street
Boston
Massachusetts - 02111
United States of America

Home Address:
Tufts Medical Center
800 Washington Street, Box 22
Boston
Massachusetts - 02111
United States of America
(617) 636-0265

Business Address:
Tufts Medical Center
800 Washington Street
Boston
Massachusetts - 02111
United States of America
(617) 636-0265

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
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
Tufts Medical Center	Boston, MA

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 30 hrs/wk
b) outpatient care 5 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2011	09/30/2012	Claims made with tail coverage

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, including the Massachusetts Board of Registration in Medicine or any other state medical board, 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: Danielle M Roncari, M.D. **License No.:** 239110

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)	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: Danielle M Roncari, M.D. **License No.:** 239110

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

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

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

6) I understand and agree to comply with my obligations to report a 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.

[X] **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.**

[X] **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.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Danielle M Roncari, M.D. **License No.:** 239110

Current Status: Active **License Expiration Date:** 4/10/2014

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Tufts Medical Center
800 Washington Street
Boston
Massachusetts - 02111
United States of America

Home Address:
Tufts Medical Center
800 Washington Street, Box 22
Boston
Massachusetts - 02111
United States of America
(617) 636-0265

Business Address:
Tufts Medical Center
800 Washington Street
Boston
Massachusetts - 02111
United States of America
(617) 636-0265

3) Email Address:

4) Fax Number: (617) 636-1490

5) Specialties
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
None Reported

9) States where you were previously licensed
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
Tufts Medical Center	Boston, MA

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2013	09/30/2014	Claims made with tail coverage

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, including the Massachusetts Board of Registration in Medicine or any other state medical board, 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: Danielle M Roncari, M.D. **License No.:** 239110

22) Have you completed all CPD requirements (100 hours of CPD 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)	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: Danielle M Roncari, M.D. **License No.:** 239110

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

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

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

6) I understand and agree to comply with my obligations to report a 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.

[X] **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.**

[X] **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.**

Physician Name: Danielle M Roncari, M.D. **License No.:** 239110

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Tufts Medical Center Indemnity Company, L	10/01/2013	09/30/2014	Claims made with tail coverage

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, including the Massachusetts Board of Registration in Medicine or any other state medical board, 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?

DANIELLE RONCARI

EDUCATION

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE — Miami, FL
Doctor of Medicine, May 2005

GOUCHER COLLEGE — Baltimore, MD
Post-Baccalaureate Premedical Certification, May 2000

COLUMBIA COLLEGE, COLUMBIA UNIVERSITY — New York, NY
Bachelor of Arts, English Literature, May 1997

TRAINING

- Tufts Medical Center and Affiliates, Boston, MA, 2005 – present
  - Administrative Chief Resident
  - Obstetrics and Gynecology Resident
- Cambridge Hospital, Cambridge, MA, 2006 – present
  - Obstetrics and Gynecology Continuity Clinic
- Magee-Women's Hospital, Pittsburgh, PA, April 2008
  - Family Planning Elective
- Planned Parenthood, Pittsburgh, PA, April 2008

HONORS

- Tufts University SOM, Third Year Clerkship Excellence in Teaching Citation (2006-2007)
- Medical Students for Choice Reproductive Health Externship (March 2005)
- University of Miami School of Medicine Scholarship (2001 – 2005)
- Magna Cum Laude, Columbia University (May 1997)
- Charles Paterno Barratt-Brown Memorial Prize *for critical writing* (March 1997)
- Dean's List, Columbia University (1993-1997)

LICENSURE

- Limited Training License Commonwealth of Massachusetts
- USMLE Steps 1, 2CS & CK, 3 – Pass

PROFESSIONAL EXPERIENCE

PLANNED PARENTHOOD, SARASOTA, FL — 2000 – 2001
Clinic Assistant

- Assisted in all surgical procedures
- Obtained patient histories
- Counseled patients on contraception and pregnancy options

CB RICHARD ELLIS INTERNATIONAL CORPORATE ADVISORY GROUP — 1997 – 1999
Research Director / Associate

DAVID NISINSON FINE ARTS — 1995 – 1997
Art Dealer Assistant

LOWELL NATIONAL HISTORICAL PARK — Summer 1995
National Park Ranger

LECTURES

- Epidural analgesia and labor, Romania, 2008
- Dealing with stress in residency, Romania 2008
- New concepts in emergency contraception, Tufts Ob/Gyn Residency, June 2008
- Surgical management of ovarian cancer, Metrowest Medical Center, April 2008
- Sexual differentiation, Tufts Ob/Gyn Residency, June 2008
- Medical abortion, Tufts Ob/Gyn Residency, October 2005

RESEARCH AND PUBLICATIONS

- Roncari, D., Davis, A. Knowledge and attitudes regarding emergency contraception among primary care physicians. Research in progress, 2008.
- Roncari, D., Lazenby, G., Fritsche, M., Liu, F., Brown, M. Planning a Regional Conference in a Hostile Environment. Poster presented at Medical Students for Choice National Meeting, New Orleans, April, 2004.
- Roncari, D. Curriculum Reform Looking Back. Medical Students for Choice Newsletter, October, 2003.
- Roncari, D., Eisermann, J. The use of the harmonic scalpel in ovarian cortical ablation for the treatment of polycystic ovarian disease. Abstract published in South Florida Institute for Reproductive Medicine, April, 2003.

INTERNATIONAL EXPERIENCE

- Kybele Project, Romania, May 2008
- Haiti Medical Trip, Medishare, 2002

VOLUNTEER AND COMMUNITY SERVICE

- Contraception Health Educator at Booker T. Washington High School, 2003
- Little Haiti Health Fair Women's Health Co-Coordinator, 2002
- Contraception Information Booth Coordinator, Primary Care Health Week at JMH, 2002
- Florida Keys Pre-Registration Committee, 2003
- Florida Keys Health Fair Participant, 2002

ACADEMIC ACTIVITIES

- Medical Students for Choice (2001-2005)
  - National Coordinator, Southeast Region, 2004 – 2005
  - Board of Directors, 2004 – 2005
  - Student Advisory Council, 2003 – 2005
  - Residency and Alumni Committee, 2004 – 2005
  - Elections Committee, 2004 – 2005
  - Conference Coordinator, Southeastern Regional Conference, Atlanta, GA, 2003 – 2004
  - Regional Coordinator, Region 10, 2003 – 2004
  - Student Coordinator, 2002 – 2003

PROFESSIONAL ORGANIZATIONS

- Association of Reproductive Health Professionals
- American College of Obstetricians and Gynecologists
- Boston Family Planning Interest Group

EXTRACURRICULAR ACTIVITIES

- Running, cooking, traveling, reading, scuba diving

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

REDACTED COPY

November 14, 2012

Danielle M. Roncari, M.D.
Tufts Medical Center
800 Washington Street
Boston, MA 02111

RE: Docket Number: 12-429

Dear Dr. Roncari:

The Complaint Committee of the Board of Registration in Medicine met on November 7, 2012, and considered the above-referenced matter. We have decided not to recommend disciplinary action and closed the complaint.

However, information concerning this matter will be kept on file at the Board. We reserve the right to reopen the complaint should you commit any violation of Board statutes or regulations in the future.

Sincerely,

Gerald B. Healy

Gerald B. Healy, M.D.
Complaint Committee Chair

GBH/ph

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

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STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

November 14, 2012

RE: Danielle M. Roncari, M.D.
Docket Number: 12-429

Dear

Thank you for the information that you provided to the Board of Registration in Medicine. A copy of your complaint, referenced above, was sent to the physician, who was required to respond in writing. Enclosed please find a copy of the physician's response.

After considering this matter on November 7, 2012, the Board's Complaint Committee did not recommend disciplinary action and closed the complaint. However, your complaint and the physician's response will be placed in the physician's file at the Board.

Thank you again for bringing this matter to the Board's attention.

Very truly yours,

Paula Hannon

Paula Hannon
Consumer Protection Coordinator

PH/bmh

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

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STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

September 18, 2012

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Danielle M. Roncari, M.D.
Tufts Medical Center
800 Washington Street
Boston, MA 02111

7011 1150 0001 3794 6741

Re: Docket Number: 12-429

Dear Dr. Roncari:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. Please provide a written response to the issues raised in the enclosed material. As part of your response, you may include any materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response and any attachments.

The Health Insurance Portability and Accountability Act (HIPAA) provides that otherwise protected health information may be disclosed to a health oversight agency for activities that include disciplinary actions. *See* 45 CFR section 164.512 (d). The Board clearly meets the definition of a health oversight agency. *See* 45 CFR section 164.501.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee.

Your response must be sent to me within thirty days of this letter. Upon receipt, your response will be reviewed to determine the course of action. You will be notified of this decision. Thank you for your attention to this request.

Very truly yours,

Paula Hannon

Paula Hannon
Consumer Protection Coordinator

PH/bmh
Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
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STANCEL M. RILEY, JR. MD.
EXECUTIVE DIRECTOR

September 18, 2012

RE: Danielle M. Roncari, M.D.
Docket Number: 12-429

Dear

The Board of Registration in Medicine has received your complaint regarding the above named physician. The physician has been asked to respond in writing to your complaint.

If you wish to bring additional information about your complaint to the attention of the Board, please provide it to me in writing at the address above. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

Once our review of your complaint has been completed, you will receive a letter informing you of the outcome.

Thank you for bringing this matter to the attention of the Board.

Very truly yours,

Paula Hannon

Paula Hannon
Consumer Protection Coordinator

PH/bmh

October 15, 2012

Ms. Paula Hannon
Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880

Re: v. Danielle M. Roncari, M.D.
Docket No. 12-429

Dear Ms. Hannon:

Thank you for your letter dated September 18, 2012, which forwarded to my attention a letter of Complaint received by the Board from a patient.

Please allow me to provide you with some information about myself. In 2005, I graduated from the University of Miami School of Medicine, with my Doctor of Medicine. Following graduation, from July 2005 and July 2008, I was a resident in Obstetrics and Gynecology at Tufts Medical Center; from July 2008 to June 2009 I was the Administrative Chief Resident at Tufts Medical Center. In 2011, I completed a two year Fellowship in Family Planning at Boston University where I was also a Clinical Research Training Program Fellow.

In 2011, I also graduated from Boston University School of Public Health where I received my Masters in Public Health, with a concentration in Maternal and Child Health.

I have worked at Boston Medical Center, Division of Family Planning, Department of Obstetrics and Gynecology (July 2009 to June 2011), Planned Parenthood League of Massachusetts as the Associate Medical Director (September 2011 to the present), Tufts University School of Medicine as an Assistant Professor (September 2011 to the present) and Tufts Medical Center, as the Director of Family Planning (September 2011 to the present). I currently hold attending privileges at Tufts Medical Center in Gynecology. (A complete copy of my curriculum vitae is attached hereto).

(DOB) presented to the Department of OBGYN at Tufts Medical Center on , 2012 for IUD removal. was initially seen by Nurse Practitioner. . Upon examination by NP , it appeared that

IUD strings were missing. NP appropriately attempted to remove the IUD with forceps that are used for this purpose however, she was unable to remove the IUD.

I was in the office at this time. NP called me to assist with the IUD removal. Upon entering the room, I introduced myself to and offered local anesthesia (intra-cervical lidocaine) to help with the discomfort. She declined. I then explained what I was going to do. I attempted to remove the IUD with the same forceps used by NP under ultrasound (US) guidance. It appeared that a large uterine fibroid was present and obstructed our view of the cavity. When told me that the procedure hurt and asked if I would stop, I stopped. At this point, I suggested that we obtain a formal US to make sure the IUD was still in place. I also raised the possibility that the IUD may have been expelled previously with heavy bleeding. left the office.

On 2012, called NP to report she thought the IUD was falling out. scheduled an appointment and returned to the office on , 2012. According to the medical records. told NP that after her previous office visit, she experienced pain and bleeding, which had lightened as of her return visit. NP examined and noted that the IUD was almost completely expelled. NP was able to remove the IUD without incident. It is my belief that that the IUD had in fact been dislodged during visits to our office on , 2012.

Prior to , 2012, I had no physician patient relationship with . I met for the first time when I was called in to see the patient by NP . I have not seen or spoken with after her 2012 visit.

I will note that at no time during my interaction with was she ever unstable or medically compromised. experienced some discomfort during the procedure, discomfort that I explained was likely to occur (which is why I offered her anesthesia to help alleviate). When asked that the procedure be stopped, it was stopped.

Contrary to comments, at no time during the 2012 procedure did I ignore or disregard her complaints of discomfort or expressed wishes to stop the procedure. I categorically deny "smirking" or behaving in an unprofessional manner as described by .

I should also note that while complained of experiencing heavy bleeding subsequent to the 2012 procedure, the medical records (attached hereto) clearly note that she was experiencing bleeding beforehand.

While I am sorry that felt that her visit on , 2012 was such a negative experience, I feel that the care and treatment provided to on 2012 by me was at all times professional and appropriate. I unequivocally deny any inappropriate conduct on behalf as alleged. I consider myself a professional and I treat all of my patients with the utmost respect, as I did with .

Thank you for allowing me the opportunity to respond to letter of Complaint. Should you have any questions or require anything further, please do not hesitate to contact either me or my attorney, Judith Carroll.

Very truly yours,

Danielle M. Roncari, MD MPH FACOG

Commonwealth of Massachusetts
Board of Registration in Medicine

COMPLAINT FORM

Return this form to: Consumer Protection Coordinator
Board of Registration in Medicine
200 Harvard Mill Square, Suite 330
Wakefield, MA 01880
Fax: (781) 876-8381

Please type or print legibly in ink. You may use the attached lined page to explain your complaint or attach your own paper to this form. Any additional information you would like to submit with your complaint must be in paper or electronic form and will not be returned. Do not send objects, tapes, or X-rays. If you have any questions, please call our Consumer Protection Unit at (781) 876-8200.

PHYSICIAN INFORMATION (*one physician for each Complaint Form*)

Roncari (last name) Danielle (first name) (middle initial)

800 Washington Street, # 22 (street address) Boston (city) MA (state) 02111 (zip code)

physician's medical specialty: OBGYN telephone number: 617-636-2229

PATIENT INFORMATION

☐ male
☒ female
last name first name middle initial

street address city state zip code

date of birth: 16 September 1969 daytime telephone number:

location of treatment: ☐ Office ☒ Hospital ☐ Nursing Home ☐ Clinic ☐ Other Department of OBGYN

date(s) the incident(s) described in the complaint happened: 2012

length of time the patient has been under the physician's care: 2 – 3 hours

COMPLAINANT INFORMATION (*Complete **ONLY** if different from the patient information*)

NOTE: *The Board will not communicate the patient's confidential medical information to you without legal proof that you are authorized to receive the information.*

☐ male
☐ female Same as patient information
last name first name middle initial

street address city state zip code

your relationship to the patient: daytime telephone number:

ACKNOWLEDGEMENT

I acknowledge that, by submitting this complaint and signing this form, the Board of Registration in Medicine may (1) obtain medical records and other information relating to this complaint; and/or (2) refer my complaint to other appropriate regulatory or law enforcement authorities. I understand that the Board may provide a copy of my complaint and all attachments to the physician.

Physician's Name: Danielle Roncari_____ Complainant's Name _____

_____ _____ _____ 27 August 2012

Complainant's signature Date

revised 8/25/2011

Physician's Name: Danielle Roncari_____ Complainant's Name _____

Briefly describe your complaint

Complaint: Clinical malpractice – caused intolerable pain during a prolonged attempt in removing of IUD and didn't stop the procedure at the patient's firm request. Unprofessional bedside manners and poor clinical judgment.

On th 2012, I went to see , a Nurse practitioner at Department of OBGYN of Tufts Medical Center, for removal of my IUD (intrauterine device).

The IUD was inserted at the end of 2011, and since that time I had some side effects (acne, headaches) that decided me to remove the device. And as advised I came for the procedure during my menses.

explained the procedure should be quick and some pressure would be felt; no local anesthesia was discussed. She made two attempts to remove the IUD, but was unable to locate the device. I tolerated the mild pain and discomfort associated with the invasive procedure.
stated that she would need to ask for help of one very experienced OBGYN doctor to remove the IUD. added that they would need to use a pelvic ultrasound during IUD removal procedure.

I was relocated to another procedure room.

Dr. Danielle Roncari with and an ultrasound technician in the procedure room following the introduction offered a local anesthesia for the operation. I asked for clarification to the anticipated level of pain and discomfort per complexity and duration of the procedure as I didn't want to go through additional pain if the procedure should be short and not painful as previously described by .

Both Dr. Roncari and explained the IUD removal should not take longer than what , initially attempted, and would use the same size of forceps for insertion into my uterus through cervix to remove the IUD under ultrasound monitoring. I agreed to proceed without an intra-cervical Novocain injection.

Dr. Roncari caused a lot of physical pain to me while trying to find the IUD in my uterus and looking at the ultrasound monitor. It took her too long to tolerate any more of severe pain, and she didn't paid attention to my vocal signs of severe adverse experience. So, I had to stop her, by saying it is very painful and I need you to stop. Dr. Roncari didn't stop the procedure; she continued to work for what it seemed another few minutes. Dr. Roncari failed to remove the IUD stating that she could not find the IUD suggesting that the IUD might no longer is in my uterus, and after that she stopped.

I was in a great pain, very hurt and angry by Dr. Roncari's unacceptable clinical judgment and response to a patient's pain and requests.
When I said to Dr. Roncari that based on her expertise she should be better at clinical judgment and treating patients without causing so much pain; that was absolutely unnecessary. Dr. Roncari didn't say anything, only smirked while leaving the procedure room.

gave me 400mg of Advil per my request, and ordered a pelvic ultrasound to ensure that IUD is still in my uterus. I spent a few days in pain and great discomfort from this adverse experience, and had heavy bleedings. I lost some work days due to the complications, pain and overall poor health state. On the following day, , I examined myself, and very easy located and felt the IUD string, a long string out of cervix in my vagina.

On the same day, , I contacted and informed her about my heavy bleeding, presence of IUD and pain. She advised to come to see her for the IUD removal on Tuesday , 2012. removed the IUD with no pain and complications.

Sincerely,