

REDACTED COPY

Application #:

253946

Board of Registration in Medicine  
Harvard Mill Square, Suite 330 - Wakefield, MA 01880  
1) 876-8210 Fax: (781) 876-8383 www.mass.gov/medboard.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.

**Type of License** ☒ Initial Full License ☐ Administrative License ☐ Volunteer License

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

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

STABINSKY SETH ALAN  
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 ☒.

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Month Day Year

Place of Birth: New York New York  
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 ECVS? (See instructions page 12) ☒ Yes ☐ No

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

Board of Registration  
in Medicine

NOV 14 2012

RECEIVED

**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.

			<u>From</u>	<u>To</u>
Facility: <u>Norwalk Hospital</u>	Position: <u>Provisional Attending</u>		<u>07/01/1991</u>	<u>12/31/1992</u>
Street: <u>34 Maple Street</u>	City: <u>Norwalk</u>	State: <u>CT</u>		
Facility: <u>St. Vincent's Hospital</u>	Position: <u>Provisional Attending</u>		<u>06/01/1992</u>	<u>12/31/1992</u>
Street: <u>2800 Main Street</u>	City: <u>Bridgeport</u>	State: <u>CT</u>		
Facility: <u>Phelps Memorial Hospital</u>	Position: <u>Provisional Attending</u>		<u>01/01/1993</u>	<u>06/30/1993</u>
Street: <u>701 North Broadway</u>	City: <u>Sleepy Hollow</u>	State: <u>NY</u>		
	<u>Clinical Instructor</u>		<u>07/01/1993</u>	<u>06/30/1994</u>
Facility: <u>Stanford Univ. Medical Center</u>	Position: <u>Clinical Assistant Professor</u>		<u>07/01/1994</u>	<u>06/30/1996</u>
Street: <u>300 Pasteur Drive</u>	City: <u>Stanford</u>	State: <u>CA</u>		
Facility: <u>Regional Medical Center</u>	Position: <u>Provisional Attending</u>		<u>03/13/2007</u>	<u>12/31/2008</u>
Street: <u>701 North Broadway</u>	City: <u>San Jose</u>	State: <u>CA</u>		

- List other states (abbreviations) where you are currently or have ever had a full license: NY NJ CT CA
- Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
  - Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☐ No
- List Board Certification(s): American Board of Obstetricians & Gynecologists Certification date: 11/12/1993  
Annual Recertification Amer Board of OBGYN since 2003 Most Recent Certification date: 01/01/2012
- List your practice specialt(ies) Obstetrics and Gynecology
- Have you completed the Opioid and Pain Management training (see Full Instructions, page5) ☒ Yes ☐ No
- Reason for requesting a Massachusetts medical license: Relocating to the State

7. Name of Facility: Currently I am interviewing for several different positions all of which require licensure.  
 Address: \_\_\_\_\_ City: \_\_\_\_\_

8. Anticipated starting date in Massachusetts: As soon as I receive a Commonwealth Medical License

9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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  11 / 09 / 2012  
 Month Day Year

(Continued on page 5)

## SUPPLEMENT FORM

PRINT NAME: SETH ALAN STABINSKY, M.D. Date: 11 / 09 / 2012

**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 or remediation by a medical school or any postgraduate training program?
3. If you are a US or Canadian graduate, did you take more than four (4) years to complete medical school; or if you are an international medical graduate, did you take more than six (6) years to complete medical school?
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: any Step of the USMLE, NBOME, FLEX, any State Board examination, any part of the National Boards, 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 / 09 / 2012

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 termination, suspension or probation proceedings instituted by any third-party payor, Medicare or Medicaid; or have you ever been restricted from receiving payments from any Medicare, Medicaid (any state), or third party payors?
14. Have you ever had an application for membership as a participating provider rejected by any third-party payor?
- 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 or has such a suit been settled, adjudicated or otherwise resolved?
- 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 / 09 / 2012

PRINT NAME: SETH ALAN STABINSKY

PAGE 2 OF 5

**Pre-medical School**

Facility: <u>Brandeis University</u>	Degree: <u>B.A.</u>	From <u>08/</u> /1978	To <u>05/23/1982</u>
Street: <u>415 South Street</u>	City: <u>Waltham</u>	State: <u>MA</u>	
Facility: _____	Degree: _____	From <u>/</u> /	To <u>/</u> /
Street: _____	City: _____	State: _____	

**Medical School**

Facility: <u>Mount Sinai School of Medicine</u>	Degree: <u>M.D.</u>	From <u>08/</u> /1983	To <u>05/29/1987</u>
Street: <u>One Gustave Levy Place</u>	City: <u>New York</u>	State: <u>NY</u>	
Facility: _____	Degree: _____	From <u>/</u> /	To <u>/</u> /
Street: _____	City: _____	State: _____	

Date of medical school graduation: May / 1987  
Month 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: <u>Albert Einstein College of Medicine</u>	Position: <u>PGY-1</u>	<u>07/01/1987</u>	<u>06/30/1988</u>
Street: <u>1825 Eastchester Road</u>	City: <u>New York</u>	State: <u>NY</u>	
Facility: <u>Saint Barnabas Medical Center</u>	Position: <u>PGY-2</u>	<u>07/01/1988</u>	<u>06/30/1989</u>
Street: <u>94 Old Short Hills Road</u>	City: <u>Livingston</u>	State: <u>NJ</u>	
Facility: <u>Saint Barnabas Medical Center</u>	Position: <u>PGY-3</u>	<u>07/01/1989</u>	<u>06/30/1990</u>
Street: <u>94 Old Short Hills Road</u>	City: <u>Livingston</u>	State: <u>NJ</u>	
Facility: <u>Saint Barnabas Medical Center</u>	Position: <u>PGY-4</u>	<u>07/01/1990</u>	<u>06/30/1991</u>
Street: <u>94 Old Short Hills Road</u>	City: <u>Livingston</u>	State: <u>NJ</u>	
Facility: <u>Stanford University Medical School</u>	Position: <u>Fellow</u>	<u>07/01/1993</u>	<u>06/30/1994</u>
Street: <u>300 Pasteur Drive</u>	City: <u>Stanford</u>	State: <u>CA</u>	

**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.

<u>Examination</u>	<u>Most Recent Date taken (Month/Year)</u>	<u>Passed (P) or Failed (F)</u>	<u>Number of attempts</u>
USMLE Step I		<input type="checkbox"/> P <input type="checkbox"/> F	
USMLE Step II		<input type="checkbox"/> P <input type="checkbox"/> F	
USMLE Step III		<input type="checkbox"/> P <input type="checkbox"/> F	
NBME Part I	<u>06/1985</u>	<input checked="" type="checkbox"/> P <input type="checkbox"/> F	<u>1</u>
NBME Part II	<u>09/1986</u>	<input checked="" type="checkbox"/> P <input type="checkbox"/> F	<u>1</u>
NBME Part III	<u>03/1988</u>	<input checked="" type="checkbox"/> P <input type="checkbox"/> F	<u>1</u>
FLEX Component 1		<input type="checkbox"/> P <input type="checkbox"/> F	
FLEX Component 2		<input type="checkbox"/> P <input type="checkbox"/> F	
FLEX Pre-1985		<input type="checkbox"/> P <input type="checkbox"/> F	
NBOME Part I		<input type="checkbox"/> P <input type="checkbox"/> F	
NBOME Part II		<input type="checkbox"/> P <input type="checkbox"/> F	
NBOME Part III		<input type="checkbox"/> P <input type="checkbox"/> F	
COMLEX Level 1		<input type="checkbox"/> P <input type="checkbox"/> F	
COMLEX Level 2		<input type="checkbox"/> P <input type="checkbox"/> F	
COMLEX Level 3		<input type="checkbox"/> P <input type="checkbox"/> F	
COMVEX		<input type="checkbox"/> P <input type="checkbox"/> F	
LMCC - Single		<input type="checkbox"/> P <input type="checkbox"/> F	
LMCC - Part I		<input type="checkbox"/> P <input type="checkbox"/> F	
LMCC - Part II		<input type="checkbox"/> P <input type="checkbox"/> F	
State Board Exam	<u>(State of examination)</u>	<input type="checkbox"/> P <input type="checkbox"/> F	



**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.

			<u>From</u>	<u>To</u>
Facility: <u>Norwalk Hospital</u>	Position: <u>Provisional Attending</u>		<u>07/01/1991</u>	<u>12/31/1992</u>
Street: <u>34 Maple Street</u>	City: <u>Norwalk</u>	State: <u>CT</u>		
Facility: <u>St. Vincent's Hospital</u>	Position: <u>Provisional Attending</u>		<u>06/01/1992</u>	<u>12/31/1992</u>
Street: <u>2800 Main Street</u>	City: <u>Bridgeport</u>	State: <u>CT</u>		
Facility: <u>Phelps Memorial Hospital</u>	Position: <u>Provisional Attending</u>		<u>01/01/1993</u>	<u>06/30/1993</u>
Street: <u>701 North Broadway</u>	City: <u>Sleepy Hollow</u>	State: <u>NY</u>		
Facility: <u>Stanford Univ. Medical Center</u>	Position: <u>Clinical Instructor</u>		<u>07/01/1993</u>	<u>06/30/1994</u>
Street: <u>300 Pasteur Drive</u>	City: <u>Stanford</u>	State: <u>CA</u>	<u>07/01/1994</u>	<u>06/30/1996</u>
Facility: <u>Regional Medical Center</u>	Position: <u>Provisional Attending</u>		<u>03/13/2007</u>	<u>12/31/2008</u>
Street: <u>701 North Broadway</u>	City: <u>San Jose</u>	State: <u>CA</u>		

1. List other states (abbreviations) where you are currently or have ever had a full license: NY NJ CT CA
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): American Board of Obstetricians & Gynecologists Certification date: 11/12/1993  
Annual Recertification Amer Board of OBGYN since 2003 Most Recent Certification date: 01/01/2012
4. List your practice specialt(ies): Obstetrics and Gynecology
5. Have you completed the Opioid and Pain Management training (see Full Instructions, page5) ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Relocating to the State
7. Name of Facility: Currently I am interviewing for several different positions all of which require licensure.  
Address: \_\_\_\_\_ City: \_\_\_\_\_
8. Anticipated starting date in Massachusetts: As soon as I receive a Commonwealth Medical License
9. Curriculum vitae (CV) listing activities by month and year must be enclosed with your application.

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 \_\_\_\_\_ 11 / 09 / 2012  
Month Day Year

(Continued on page 5)

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 **were required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPEs web site at [www.NPPEs.cms.hhs.gov](http://www.NPPEs.cms.hhs.gov).

My current NPI is:

1	8	3	1	2	7	9	4	1	3
---	---	---	---	---	---	---	---	---	---

**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.

**Please sign and date to confirm that all of the information on this form is true and accurate.**

Signature: \_\_\_\_\_



11 / 09 / 2012  
Month Day Year



**MALPRACTICE HISTORY**

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

**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. PLEASE SEND A LETTER THAT COVERS ALL OF THE PERIODS LISTED BELOW.**

**Liability Carrier:** National Union Fire Insurance (Marsh USA)  
**City:** Nyack **State:** NY **Policy #** 6793286

**From:** 06/2006 **To:** 12/2008

**Liability Carrier:** \_\_\_\_\_ **From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Liability Carrier:** \_\_\_\_\_ **From:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **To:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Applicant's signature:** \_\_\_\_\_ **11 / 29 / 2012**  
**Date**

**Print Name:** SETH A. STABINSKY, M.D.

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**State:** \_\_\_\_\_ **Zip code:** \_\_\_\_\_

**Additional forms available at the Board's website at [www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)**

**MALPRACTICE HISTORY****Board of Registration in Medicine**

200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880

Telephone: (781) 876-8210 Fax: (781) 876-8383 www.mass.gov/massmedboard

**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. PLEASE SEND A LETTER THAT COVERS ALL OF THE PERIODS LISTED BELOW.

Liability Carrier: Norcal Mutual Insurance Company From: 01/2011 TO 05/27/2012 SASSO 11/27/12  
City: San Francisco State: CA Policy # 610423

Liability Carrier: Norcal Mutual Insurance Company From: 04/2010 TO 04/2013 SASSO 11/27/12  
City: San Francisco State: CA Policy # 610359

Liability Carrier: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_ Date: 10 / 18 / 2012

Print Name: SETH A. STABINSKY M.D.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Additional forms available at the Board's website at www.mass.gov/massmedboard

10/22/2012 10:23 AM

**MALPRACTICE HISTORY**

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

**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. PLEASE SEND A LETTER THAT COVERS BOTH OF THE PERIODS LISTED BELOW.

Liability Carrier: Federal Torts Claims Act From: 01/2011 To: 06/2012  
City: Boston State: MA Policy # 1-F00000132-10-01

Liability Carrier: Federal Torts Claims Act From: 03/2010 To: 12/2010  
City: Boston State: MA Policy # 1-F00000085-09-01

Liability Carrier: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant's signature: \_\_\_\_\_ 11 / 09 / 2012  
Date

Print Name: SETH A. STABINSKY, M.D.

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**Additional forms available at the Board's website at [www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)**

**Telephone: (781) 876-8210    Fax: (781) 876-8383    [www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)**

**Additional forms available at the Board's website at [www.mass.gov/massmedboard](http://www.mass.gov/massmedboard)**





Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Seth A Stabinsky, M.D.

License No.: 253946

Current Status: Active

License Expiration Date: 11/16/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

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

Arizona  
California  
Connecticut  
New Jersey  
New York

9) States where you were previously licensed

None Reported



**Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application**

**Physician Name:** Seth A Stabinsky, M.D.

**License No.:** 253946

**10) Work Sites**

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

**WorkSite**

**Location**

None Reported

**11) Care of patients in Massachusetts**

**Average weekly hours involved in:**

**a) inpatient care** 0 hrs/wk

**b) outpatient care** 0 hrs/wk

**12) Medical Liability Insurance Information**

**I am not required to have malpractice insurance.**

**Not involved with direct or indirect patient care in Massachusetts.**

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

**14) Claims Made**

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

**15) Claims Closed**

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

**16) Other Civil Lawsuits**

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

**17) Criminal Charges**

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

**18) Other Issues**

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





**Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application**

**Physician Name:** Seth A Stabinsky, M.D.

**License No.:** 253946

---

- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?
- 22) 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 you are renewing your license for the first time, please answer Yes) Yes



**Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application**

**Physician Name:** Seth A Stabinsky, M.D.

**License No.:** 253946

---

**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:** Seth A Stabinsky, M.D.

**License No.:** 253946

**Compliance with Legal Responsibilities**

**Online profile:**

☒ 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.

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

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

## **SETH A. STABINSKY, M.D., FACOG**

### **SUMMARY OF QUALIFICATIONS**

Twenty-five years of private, academic, and not-for-profit medical practice combined with cross-functional corporate operations, analysis and fundraising expertise provides a unique ability to deliver:

- A contagious, positive, team-approach to leadership, patient care, teaching, and learning that facilitates a close working relationship with patients, colleagues, payers, and government;
- Data-driven assessments of health care delivery strategies for agencies wishing to control costs while improving clinical outcomes;
- Concise and clear, market-based needs assessment followed by strategic and tactical execution of agency goals
- Creative problem solving that incorporates ethical, patient, employee and payer imperatives;
- Unambiguous communication that inspires donor, community, and government involvement

### **OBJECTIVE**

To leverage outstanding clinical and business acumen in service to the medically underserved of Massachusetts; to work closely with Senior Management to strategically and tactically respond to the demands of healthcare reform.

### **LICENSURE**

**Physician and Surgeon: Active-California; New York; Connecticut; Inactive-New Jersey**

### **EDUCATION**

**01/2012 – University of Massachusetts Napa CA Infant-Parent Mental Health Post-Graduate Certificate Program  
(Completion will be 04/11/2013)**

P.O. Box 2555 Napa, CA 94588 [http://www.umb.edu/editor\\_uploads/images/cia\\_p\\_z/2013-2014\\_Application\\_Packet\\_-\\_Napa.pdf](http://www.umb.edu/editor_uploads/images/cia_p_z/2013-2014_Application_Packet_-_Napa.pdf)

**07/1993 – 06/1994: Dept. of ObGyn - Stanford Medical School, SRS Surgical Endoscopy Fellow**

Society of Reproductive Surgeons of the American Society of Reproductive Medicine laparoscopic and hysteroscopic surgery fellowship  
300 Pasteur Dr. Stanford, CA 94305

**07/1988 – 06/1991: Saint Barnabas Medical Center, Obstetrics and Gynecology Resident**

94 Old Short Hills Rd. Livingston, NJ 07039

**07/1987 – 06/1988: Albert Einstein College of Medicine, Obstetrics and Gynecology Intern**

1825 Eastchester Rd. Bronx, NY 10461

**08/1983 – 05/1987: Mount Sinai School of Medicine, Doctor of Medicine**

One Gustave Levy Place. New York, NY 10029: 212.241.6500

**08/1978 – 05/1982: Brandeis University, Bachelor of Arts (Psychology), *cum laude***

415 South St. Waltham, MA 02453

### **Sabbatical 5/26/12 to Present**

I voluntarily resigned from Tiburcio Vasquez Health Center on 5/26/12 in anticipation of spending the summer with my family, while concentrating on the UMASS Napa Fellowship and identifying clinical employment in the Northeast. It has been a far slower process than I had anticipated but is completely unrelated to any physical or mental illness that could affect my ability to practice. I am and have been well and am 100% fit for patient care.

## CLINICAL PRACTICE AND RESEARCH EXPERIENCE

### **01/2011 – 05/2012 Medical Director: Tiburcio Vasquez Health Center (TVHC)**

Direct patient care and supervision of Providers, Nursing, Pharmacy, Medical Records, and Referrals for this Federally Qualified Health Center (FQHC), which delivers quality, multidisciplinary, culturally and linguistically sensitive health care and social services at more than a dozen locations in Alameda County, CA; also sit on the Medical Director's Committee of the Community Health Center Network, TVHC's Medical Service Organization (MSO) and Local Extension Center (LEC) of the Office of the National Coordinator for Health Information Technology (ONCHIT), TVHC's partner in planning the successful implementation of electronic health records (EHR). 33255 Ninth Street Union City, CA 94587 510.471.5880

#### References-

Jody Crossman, RN, Director of Nursing 415-518-3009  
Margie Burton Flores, Psy.D., Director of Behavioral Health 510-432-0896  
Hsin Liu, M.D, ObGyn Provider 917-324-2793

### **03/2010 – 01/2011 Chief Medical Officer: Livingston Medical Group (LMG)**

Responsibilities included oversight of all Clinical Operations for this FQHC, which serves a base of 13,000 patients via 50,000+ unique annual encounters. 1140 Main Street Livingston, CA 95334 209.394.7913

Reference – Loretta Khangura, RN, former Director of Quality Assurance & Improvement: 209.201.1850

- Non-profit corporate officer reporting to the CEO
- Direct reports: All health-care providers; managers of Nursing, Quality, Referrals, Laboratory and X-ray Services; Special Projects Manager (major role in recent upgrade of Practice Management System). Indirect reports: All clinical staff
- Corporate liaison to the Central Valley Collaborative, LMG's LEC
- Direct line responsibility for a substantial portion of the center's \$7 million annual budget
- 20-hours per week of direct patient care

### **01/2009 – 01/2010: Cardiva Medical, Inc., Full-Time Consulting Medical Director**

Cardiovascular medical device company designing, manufacturing, researching, and marketing vascular closure devices  
888 W. Maude Ave. Sunnyvale, CA 94085

Reference – Glenn Foy, former President & COO: 925.989.3544

- Class III cardiovascular device first-in-man clinical trial; responsible for design, planning, execution and completion of final report and preparation for follow-on CE Mark and PMA pivotal trials

- Responsible for providing general outpatient Obstetrics and Gynecology care and overseeing mid-level providers (half time)

### **06/2006 – 12/2008: EASy Gyn Clinical and Research Centers of North America, Inc., CEO & Medical Director**

Providing in-office hysteroscopic sterilization and treatment of menorrhagia for women with completed child bearing and consulting services for women's health care stakeholders

125 North Jackson Ave., Ste. 106. San Jose, CA 95116

Reference – Gloria Cruz, Office Manager: 408.363.1731

- Solo practitioner/founder of in-office gynecological surgery practice

### **01/2006 – 05/2006: Spectros Corporation, Clinical Development Consultant**

Early-stage medical device company leveraging core competence in optical spectroscopy  
4370 Alpine Rd. Portola Valley, CA 94028

Reference – Michael Fierro, VP, Research & Development: 650.851.4040

- Responsible for market strategy and clinical trial development

## **CLINICAL PRACTICE AND RESEARCH EXPERIENCE (cont.)**

### **07/2005 – 12/2005: Cardiva Medical, Inc., Half-Time Consulting Medical Director**

Cardiovascular medical device company designing, manufacturing, researching, and marketing vascular closure devices  
888 W. Maude Ave. Sunnyvale, CA 94085  
Reference – Glenn Foy, former President & COO: 925.989.3544

- Charged with data collection and submission of vascular closure 510(k) to FDA

### **07/2005 – 12/2005: Palo Alto Investors, Half-Time Buy-Side Analyst Intern**

At that time, a \$900M hedge fund with health care group managing \$300M in assets  
470 University Ave. Palo Alto, CA 94301  
Reference – Joon Yun, M.D., Managing Director: 650.325.0772

- Introduction to investment research of privately held and public pharmaceutical, biotechnological, and medical device companies

### **07/2003 – 06/2005: Adiana, Inc., Vice President and Medical Director**

Early-stage company boasting second to market, trans-cervical sterilization system; acquired by Hologic, Inc.  
250 Campus Dr. Marlborough, MA 01572  
Reference – Doug Harrington, Founder and VP, Research & Development: 408.375.7009

- Responsible for medical oversight of 10 center, 650 patient, international randomized controlled clinical IDE pivotal trial, which provided the clinical data on which FDA based its PMA approval
- Investigator training and subsequent personal supervision of 450 hysteroscopic sterilization procedures

### **01/1999 – 06/2003: Sanarus Medical, Inc., Founder, Vice President and Medical Director**

Cryo-technology company redefining minimally-invasive diagnosis and treatment of breast disease  
7068 Koll Center Parkway, Suite 425, Pleasanton, CA 94566  
Reference – Glenn Foy, former President & CEO: 925.989.3544

- Directly responsible for all clinical trials and FDA 510 (k) submissions, which led to clearance/marketing of rotational core biopsy and interstitial cryoablation devices, a cryo-assisted lumpectomy procedure, and initiation of a study designed to evaluate the treatment of breast carcinoma utilizing interstitial cryoablation
- Created comprehensive curriculum/managed physician training program and scientific advisory board

### **07/1998 – 12/1998: Novacept, Inc., Vice President of Medical Affairs**

Early-stage company offering revolutionary bipolar radiofrequency endometrial ablation technology; acquired by Hologic, Inc.  
250 Campus Dr. Marlborough, MA 01572  
Reference – Eugene Skalny, M.D., VP, Medical Affairs (my replacement): 650.245.8866

- Transitional role while waiting to start Sanarus Medical, Inc.
- Responsible for early implementation of multicenter, randomized controlled pivotal study for Novasure™ PMA
- Site selection, initiation, investigator training; managed MAB; recruited replacement

### **07/1996 – 06/1998: Gynecare, Inc., Associate Medical Director**

Women's health medical device company that became the cornerstone of Johnson & Johnson's Gynecare Division  
Route 22 West. Somerville, NJ 08876  
Reference: Milt McColl, M.D., former Chief Medical Officer: 650.520.7284

- Responsible for clinical portion of ThermoChoice™ PMA
- Leadership role in VersaPoint™ 510 (k) clearance requiring clinical study
- Directed ThermoChoice nationwide physician training program (3,000 gynecologists over 4-month period);
- Clinical director for gynecology franchise post Johnson & Johnson acquisition



## CLINICAL PRACTICE AND RESEARCH EXPERIENCE (cont.)

### **07/1993 – 06/1996: Dept. of ObGyn-Stanford University Medical School, Assistant Professor**

300 Pasteur Dr. Stanford, CA 94305

Reference: Bertha Chen, M.D., Assoc. Professor: 650.725.6079

- General Obstetrics and Gynecology practice
- Director of Medical Student Clerkships
- Acting Division Chief, General Gynecology (1994-1995)

### **01/1993 – 06/1993: Richard Chelson, M.D., P.C., Locum Tenens Obstetrician and Gynecologist**

100 S. Highland Ave. Ossining, NY 10562

Reference: Connie Long, M.D.: 914.524.9612

- Private practice of general ObGyn while awaiting start of surgical endoscopy fellowship at Stanford University

### **06/1992 – 12/1992: Saint Vincent's Hospital, Consulting Obstetrician and Gynecologist**

2800 Main St. Bridgeport, CT 06606: 203.576.6000

- One 24-hour shift per week managing ObGyn clinic, labor and delivery, and surgical gynecology service

### **07/1991 – 12/1992: Medical Center OBGYN, P.C., Full-Time Obstetrician and Gynecologist**

40 Cross St. Norwalk, CT 06851: now closed

- Private practice general obstetrics and gynecology

## PUBLICATIONS

Kung RC, Vilos GA, Thomas B, Penkin P, Zaltz AP, Stabinsky SA. A new bipolar system for performing operative hysteroscopy in normal saline. J Am Assoc Gynecol Laparosc 1999 Aug;6(3):331-6.

Stabinsky SA, Einstein M, Breen JL. Modern treatments of menorrhagia attributable to dysfunctional uterine bleeding. Obstet Gynecol Surv 1999 Jan;54(1):61-72.

Shah AA, Stabinsky SA, Klusak T, Bradley KR, Steege JF, Grainger DA. Measurement of serosal temperatures and depth of thermal injury generated by thermal balloon endometrial ablation in *ex vivo* and *in vivo* models. Fertil Steril 1998 Oct;70(4):692-7.

Amso NN, Stabinsky SA, McFaul P, Blanc B, Pendley L, Neuwirth R. Uterine thermal balloon therapy for the treatment of menorrhagia: the first 300 patients from a multi-centre study. International Collaborative Uterine Thermal Balloon Working Group. Br J Obstet Gynaecol 1998 May;105(5):517-23.

Vilos GA, Fortin CA, Sanders B, Pendley L, Stabinsky SA. Clinical trial of the uterine thermal balloon for treatment of menorrhagia. J Am Assoc Gynecol Laparosc 1997 Nov;4(5):559-65.

Philipps AF, Porte PJ, Stabinsky S, Rosenkrantz TS, Raye JR. Effects of chronic fetal hyperglycemia upon oxygen consumption in the ovine uterus and conceptus. J Clin Invest 1984 Jul;74(1):279-86.