Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

COMPLETED

Physician Registration Renewal Application

COMPLETED

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

REDACTED COPY

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

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

1. Current Status: Active Registration No.: 60491 Renewal Date: 04/28/2001

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

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

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

3. A) Mailing/Business Address:
ALAIN LESTER CAMPBELL
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

B) Home Address:

RECEIVED APR 2 4 2001 Board of Registration in Medicine

Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (781) 592-3000

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

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: b) Sex: M

c) SS#:

5. a) Name of Medical School:

McGill University Faculty of Medicine

b) Year Graduated: 1976 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass. 40

OBG 0 Obstetrics and Gynecology
0

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)

b) States where you were previously licensed (Abbr.)

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 537/✓ (AP) 10 % Facility Code: 538/✓ (AP) 10 % Facility Code: ___/___ (AP) ___ %
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: CAMPBELL LICENSE NUMBER: 00991

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: PRO MUTUAL # 1-31022 Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 35 hrs/wk b) inpatient care 5 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 5 %

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

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 04/19/01

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

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

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

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

RECEIVED
APR 27 1999
Board of Registration in Medicine

Before proceeding, please read the instruction booklet.
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Registration No.: 60491 Renewal Date: 04/28/1999 1. Current Status: Active

If you want to change your current status, please indicate below: (Check one).

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see below *) ☐ Do not wish to renew

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

3. A) Mailing/Home Address:

ALAIN LESTER CAMPBELL, M.D.

B) Business Address:
ATLANTICARE OB/GYN
9 BOSTON STREET
EAST LYNN, MA 01904

Home Phone:
Business Phone: (781)592-3000

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

5. A) Name of Medical School:
McGill University Faculty of Medicine
B) Year Graduated: 1976 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: 9 BOSTON ST, SUITE 9
City/Town: LYNN State: MA.
Zip: 01904 Country: USA

HOME: PLEASE DO NOT CIRCULATE
Other Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

Home: _____
Business: (_____) _____

Date of Birth: (M/D/Y): __/__/__ Sex: ☐ M ☐ F
SS#: _ _ _ - _ _ - _ _ _ _

Full Name of Medical School:
_____
_____

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

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

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Abbr: _ _ _ _
Abbr: _ _ _ _

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Last Name: CAMPBELL Registration Number: 60491

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 81 ✓ (AP) 48 % Facility Code: 421 ✓ (AP) 4 % Facility Code: 141 ✓ (AP) 48 %

Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %

If 999, print name(s): ___

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: MEDICAL INTER. INS EX # 100437721 STORER MBS INSURANCE Alternatively, indicate as follows:

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

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

Please explain exemption: ___

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 4 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ Training Program exemption

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

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: [signature] Date: 04/26/99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.
- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Registration No.: 60491 Renewal Date: 04/28/97

1. Activity Status: (Check only one) ☑ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

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

3. A) Mailing/Home Address:

ALAIN LESTER CAMPBELL, M.D.

B) Business Address:
ATLANTICARE OB/GYN
9 BOSTON STREET
LYNN, MA 01904

Home Phone:
Business Phone: (617)592-3000

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 10/19/88 D) SS#:

5. A) Name of Medical School:

McGill University Faculty of Medicine
B) Year Graduated: 76 C) Degree: MD

6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.
OBG	64 Obstetrics and Gynecology

Corrections (type or print)

Other Name(s): _____

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

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

Home: (___) _____
Business: (___) _____

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Mass.
O B G	40 Obstetrics And Gynecology

If OS, Print Specialty: _____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr:

Abbr: ____ ____ ____ ____

Abbr: ____ ____ ____ ____

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts**

(11)

PRINT NAME AND NUMBER: Last Name: CAMPBELL Registration Number: 60491

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).

Facility Code: 0 08 / ✓ (AP) Facility Code: ___ ___ / ___ (AP) Facility Code: ___ ___ / ___ (AP)
Facility Code: 0 1 4 / ✓ (AP) Facility Code: ___ ___ / ___ (AP) Facility Code: ___ ___ / ___ (AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ___ b) Letter of Credit

Name of Insurer: AMERICAN MEDICAL MUTUAL

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a) ___ Not involved in direct/indirect patient care in Massachusetts b) ___ Otherwise exempt

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 32 hrs/wk b) inpatient care 8 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 5 %

PART A

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

IN THE PAST TWO (2) YEARS:

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

☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption

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

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

Signature _____ Date: 02 / 25 / 97

Wallet card to Dr on 5/2/95

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
60491	ACTIVE	$250.00	04/28/95	$25.00

Mailing Address:
ALAIN LESTER CAMPBELL, M.D.

Correction of Mailing Address

Address (Mailing): ____________
City/Town: ____________
State: ____________
Country: ____________

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

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

[redacted]

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. Business Address:
ATLANTICARE OB/GYN
493 WESTERN AVENUE
LYNN, MA 01904

3. Date of Birth: Sex: M
Lic. Issue Date: 10/19/88 SS#:

Home Phone Business Phone
(617)592-3000

4. Name of Medical School:
McGill University Faculty of Medicine
Year Graduated: 76 Degree: MD

Corrections of Pre-Printed Information

Name: ATLANTICARE OB/GYN
Address: 225 BOSTON ST, SUITE 205
City/Town: LYNN
State: MA Zip: 01904
Country: USA

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

Home: ( ) ____ Business: ( ) ____

Full Name of Medical School: ____________

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

5. a) Other states where you are now licensed to practice (Abbr): NONE
b) States where you previously were licensed to practice (Abbr): QUEBEC, CANADA

6. Specialty Code(s) (See Table 1):
Code Hours per Week in Mass.
OBG 64 Obstetrics and Gynecology

Code ____ Hours per Week in Mass. ____
If OS, print specialty: ____________

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

Code: ____ Code: ____

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

Federal (DEA): ____________
Mass: ____________

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

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

PRINT NAME AND NUMBER: Physician Last Name: CAMPBELL Registration Number: 60491

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 014 / X (AP) Facility Code: 008 / X (AP) Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

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

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit ___ If applicable, check one.
List Insurer: Medical MAP. but Underw. Ass., MA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___
State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No X (Check one)

13. a) What is your principal work setting? (See Table 4) 10

b) Care of patients in Massachusetts (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 17 hrs/wk
ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 45 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 0 %

Questions **14 through 24** refer to **the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details – Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested ___
No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: 04/28/95

I. PHYSICIAN INFORMATION

ALAIN LESTER — *First Name* — *Middle Initial*
CAMPBELL — *Last Name* — *Suffix*

Make changes to name here

Mass License # 60491
License Status Active

First Issue Date 10/19/88

Hospital Affiliation

Atlanticare Ob/Gyn
225 Boston St,Suite 205
Lynn, MA 01904
U.S.A.
(617) 592-3000

AtlantiCare Medical Center
North Shore Medical Center-Salem Hosp

Make address corrections here:
ATLANTICARE OB/GYN
9 BOSTON ST
LYNN, MA 01904, USA
(617) 592-3000

Make any corrections to above here:

Insurance Plan Affiliation:
HARVARD-TUFTS-BCBS
PRIVATE, INDEMNITY PLANS, HMOS, PPO, MEDICARE, MEDICAID

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☒ Yes ☐ No
Accept Medicaid? ☒ Yes ☐ No

II. EDUCATION & TRAINING

McGill University Faculty of Medicine — *Medical School* — MD — *Degree* — 76 — *Date*

Make corrections here

McGILL UNIVERSITY - MONTREAL GENERAL HOSPITAL - JEWISH GENERAL HOSPITAL — *Residency Program(s)* — *Start* JULY 76 To — *End* JUNE 77

UNIVERSITY OF MONTREAL GENERAL SURGERY-UROLOGY HOTEL-DIEU HOSPITAL — *Residency Program(s)* — *Start* JULY 77 to — *End* JUNE 78

UNIVERSITY OF MONTREAL HOTEL-DIEU HOSPITAL - STE-JUSTINE HOSP-TERTIARY CENTER — *Residency Program(s)* — *Start* JULY 78 TO — *End* JUNE 80

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint .....

.....

.....

VII. MALPRACTICE

Details of claims paid for Dr. CAMPBELL

No. of Years in Practice: #

Date	Amount Paid 0.0000	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
1972 STUDENTSHIP, NATIONAL RESEARCH COUNCIL OF CANADA	
1972-73 RESEARCH BURSARY, McGILL UNIVERSITY	
1976 M.Sc. DEGREE EXPERIMENTAL MED. (ENDOCRINOLOGY), McGILL UNIVERSITY	
.....	.....
.....	.....
.....	.....

Note: Please return the survey in the enclosed envelope to:

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
60491	ACTIVE	$250.00	04/28/93	$25.00

Mailing Address:
ALAIN LESTER CAMPBELL, M.D.

Correction of Mailing Address:
Address (Mailing): _____
City/Town: _____
State: _____
Country Code (See Table 1): _____

Directions: **Staple check to bottom of form. Add late fee if necessary.**
- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.
- Before proceeding, please read the instruction booklet. Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. APR 27 1993
Pr. APR 27 1993
Bk/D.E. 4/27/93 EM

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2. a) Address (Home):

   b) Address (Business):
   ATLANTICARE OB/GYN
   493 WESTERN AVENUE
   LYNN, MA 01904

3. Date of Birth: Sex: M
   Lic. Issue Date: 10/19/88 SS#:
   Telephone Number:
   Home Business
   (617)592-3000

4. Name of Medical School:
   McGill University Faculty of Medicine
   Year Graduated: 75 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): NONE
   b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.
OOG	64
0	

   Obstetrics and Gynecology

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: OG Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

8. Drug License Number(s), if any: a) Federal (DEA)
   b) State (MA)

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): _____
City/Town: _____
Country Code: _____ If 999 print Country: _____

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

Full Name of Medical School: _____

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

Quebec

Code	Hours per Week in Mass.

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

Federal (DEA): _____
State (MA): _____

9. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested _____
   You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: CAMPBELL Registration Number: 60491

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: MED. MALP. JOINT UNDERW. ASS., MA.

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am
(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___
(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 008 / X (AP) Facility Code: 062 / X (AP) Facility Code: ___ / ___ (AP)
Facility Code: 0134 / X (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes___ No X (Check one)

14. a) What is your principal work setting? (See Table 5) 15

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 34 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 30 hrs/wk in MA

Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

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

- **I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.**

- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: [signature] Date: 4/26/93

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1991-1993 Physician Registration Renewal Application

Hand Delivered

Registration No.	Status	Fee	Renewal Date
60491	ACTIVE	$150	04/28/91

Dr. ALAIN LESTER CAMPBELL

For Office Use Only

M.R.		/ /
Pr.		/ /
Bk.		/ /
Ch.	BR	4/29/91
D.E.		

Directions:

- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:

I am applying to be registered with the following status: Active XX Inactive_____

I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information

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

2. a) Address (Home):

2. b) Address (Business):
ATLANTICARE OB/GYN
493 WESTERN AVENUE
LYNN, MA 01904-

3. Date of Birth: Sex: M
Lic. Issue Date: 10/19/88 SSN #:
Telephone Number:
Home Business
(617)592-3000

4. Medical School Code: QU001 Year Graduated: 76 Degree: MD
Name of School:
Faculty of Medicine, McGill University

5. a) Other States where you are now licensed to practice (*Abbr*): none
b) States where you previously were licensed to practice (*Abbr*): Quebec, Canada

6. Specialty Code(s) (*See Table 3*):

Code	Hours per Week in Mass.	
03G	0	Obstetrics and Gynecology
	0	

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:
Code: OG Board of Obstetrics and Gynecology
Code:

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) _____ b) How many DEA nos. do you have? 1
c) State (MA) #M_ _____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES XX Waiver Requested____
(You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See Instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*

30M - 9/90 - P813971

[For Office Use Only: Waiver Granted_____ Date:____/____/____]

Corrections of Pre-Printed Information

Name:_____

Address:_____
City/Town_____
State:_____ Zip:_____
Country Code:_____ (If 999 write Country):_____
Address:_____
City/Town:_____
State:_____ Zip:_____
Country Code:_____ (If 999, write Country):_____

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

Home: (____)_____ Business: (____)_____

School Code:_____ Year Graduated:_____ Degree (MD/DO):_____
If 99999, write School:_____

___	___	___	___	___	___	
___	___	___	___	___	___	

Code	Hours per Week in Mass.
___ ___	40
___ ___	

If OS, write specialty:_____

Code:_____
Code:_____

FILL IN NAME AND NUMBER:

Physician Last Name: CAMPBELL ALAIN LESTER Registration No.: 60491

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER xx or (b) LETTER OF CREDIT_____. If applicable, check one.

List Insurer: MED. MALP. JOINT UNDERW. ASS., MA.

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

(State how otherwise exempt):_____

11. Current Hospital Affiliations *(Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).*

Facility Code: 008 xx(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

Facility Code: 014 xx(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

If 999, write Name(s):_____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code: 998 Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No xx (Check one.)

b) If you are in a MA program, are you a I) Resident____ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program?_____hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 14 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 50 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 10

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A. Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?		

Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.

I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.

Signature: _____ Date 4/27/91

88-00806

AFD

THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — $150.00 must accompany APPLICATION — No currency or personal checks)

Filed 4/7/88
By JML
Form of Fee CK

For Office Use

Application # 64040
Certificate # 60491 Date of Issue 10/19/88

Please Print

SWORN STATEMENT

Date: March 11th, 1988.

Name Alain Lester CAMPBELL
First Middle Last

Address

Date of Birth

Place of Birth St-Hyacinthe, Quebec, Canada

Pre-Medical Education

School University of Montreal

Years Attended B.Sc. : 1969-72
previously: B.A. (Univ. Mtl, 1969)

Medical Education

School McGill University

Years Attended 1972-76 : M.D. , C.M.

Postgraduate Education & Hospital Appointments

Place	Position	Dates
POSTGRADUATE EDUCATION: M.Sc. (Experimental Medicine - Endocrinology) McGill Univ.		1972-1976
Residency program: OB/GYN: McGill Univ. and Univ. Mtl;		1977-80
Appointments: Assistant Prof Clinical OB/GYN , Fac Medicine and Graduate Studies, Univ. Montreal, Ste-Justine and Hôtel-Dieu University Hospitals;		1981-actual 1988;

List all other states in which you have been fully licensed: QUEBEC, only, Canada. 77-182

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

I never took the Canadian L.M.C.C. or F.R.C.S. exams;
This application for full licence or licence restricted to OB/GYN
as I am certified by an American Specialty Board. I have
made a commitment to join an OB/GYN practice at Atlantic Care
Medical Center, in Lynn, Mass., on July 1st 1988, which is a
designated Medically Underserved area in OB/GYN; they are relying
on me to begin treating patients on July 1st 1988

Thank you

J. Campbell M.D.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
FULL LICENSE

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alain L. CAMPBELL

PERMANENT ADDRESS: - AVE

LOCAL MAILING ADDRESS IN (MA): -

HOSPITAL: Ste-Justine Hospital

ADDRESS: 3175 CÔTE SAINTE-CATHERINE, Montreal, Quebec, Canada H3T 1C5

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.	
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.	
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.	
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.	
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.	
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____, _____.	18.	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: A. Campbell DATE: March 11th, 1988

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

HAND Delivered 4/21/89

008264

Board Use Only:

Registration No.	Status	Fee	Renewal Date
60491	1	$150	04/28/89

ALAIN LESTER CAMPBELL

M.R. BR 4/21/89
Pr. DCB 4/21/89
Bk.
Ch. Stea 4/21/89
D.E.
Fl.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--***It is not adequate to state that the Board already has the information.**
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) CAMPBELL (FIRST:) ALAIN (M.I.:) L

1. b) Other Name(s), if any, that you were ever licensed under: NOT APPLICABLE

2. a) Address (Mailing): SAME AS ABOVE

2. b) Address (Home): SAME AS ABOVE

2. c) Address (Business): ATLANTICARE OB/GYN
493 WESTERN AVE., LYNN, MA. 01904

2. d) Telephone (Business): (617) 592-3000 Extension ---- 2. e) Telephone (Home) *(Optional)*: ( ) -

3. Date of Birth (MO/DA/YR): 4. Sex: MALE X FEMALE 5. Social Security No. *(Optional)*:

6. a) Medical School Code *(See Table 1)*: QU001 *If 99999, write* Name: ------

6. b) Year Graduated: 1976 6. c) Degree: M.D. XX D.O.

6. d) Country: U.S. Canada X Code if Other *(See Table 2)*: --- *If 999, write* Name: - - -

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

10 Hospital	50 %	15 Private Office	%	20 Partnership/Group Practice	30 %
25 Clinic	20 %	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	%	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

8. Professional Activity *(Circle and Indicate Percent(%) of Professional Time)*:

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	90 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 1019/88
30 Administrative Activities	%	40 Medical Teaching	%	
50 Medical Research	10 %	99 Other	%	

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 100 % Specialty Code: Percent of Practice Time: %
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) Y *10. b) If YES, circle which Board(s):*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	(OG)	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*

Facility Code: 008 100% Facility Code: % Facility Code: %
Facility Code: % Facility Code: % Facility Code: %

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

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

If 999, write Name(s): 998 : MONTREAL : STE-JUSTINE UNIVERSITY HOSPITAL
MONTREAL : HOTEL-DIEU UNIVERSITY HOSPITAL

I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) 3 attached pages--is true.

Signature: M Campbell (See reverse side) Date: April 21, 1989

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

Fill in name and number. **Physician Last Name:** CAMPBELL **Registration No.:** 60491

12. a) Other States where you are now licensed to practice (*Abbreviate*): S QU

12. b) States where you previously were licensed to practice (*Abbreviate*): QU

13. I am applying to be registered with the following status: ACTIVE XX INACTIVE *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 40 hrs., Category II: 60 hrs., (Risk-Management: 10 hrs.); Residency Program in: ;
Waiver Requested ___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT ___. *If applicable, check one and identify the name.*
Insurer: MED MAL. JOINT UNDERW ASS. MA Institution issuing Letter of Credit: _____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* _____

14. c) Percent of Practice Time in Massachusetts: 100 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations–*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___		

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Medical Board requires this form to be completed by each state wherein I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise, direct to the Board of Registration in Medicine. 10 West Street, Boston, Massachusetts 02111. Your early response is appreciated. This form must come directly from the state licensing board.

NOTE: Some states charge a fee for this service. We suggest that you call the different states in which you are licensed before you mail this form.

(signature) M.D.

NAME: CAMPBELL DR ALAIN

ADDRESS: ____

My license number is: 77-182

(DO NOT DETACH)

~~State of~~ Province of Québec

Full Name of Licensee: Alain CAMPBELL, M.D.

Graduate of: McGill, 1976

License No.: 77-182 Issued date: June 17th, 1977

By: Endorsement/Reciprocity with Diploma which includes oral and written examinations.

By: Your State Board's Written Examination N/A

License is current? Yes If NO, Why Not? ____

Has license been suspended or revoked? No If YES, Why? ____

Has licentiate ever been on probation? No If YES, Why? ____

Has license ever been requested to appear before your Board? No

If YES, Why? ____

Derogatory information, if any N/A

Comments, if any Doctor Campbell is a certified specialist in Obstetrics-Gynaecology since February 27th, 1981.

Signed: ____

Jacques Brière, M.D.

Title: Assistant Secretary general

BOARD SEAL

State Board: Professional Corporation of Physicians of Québec

Date: January 22nd, 1988

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
AMERICAN SPECIALTY BOARD

FOR OFFICE USE ONLY
Specialty License Application ____
Pending ____ Approved ____
License # ____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: CAMPBELL DR ALAIN L -
PERMANENT ADDRESS: ____

LOCAL MAILING: ca Beforze
ADDRESS IN (MA): ____

HOSPITAL: ____
ADDRESS: ____

Applying on the basis of which approved American Specialty Board? OB/GYN

Certificate Category? ____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?		
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever failed an American Specialty Board examination?		
8. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
9. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?		
10. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
11. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.		
12. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
13. Have you ever, for any reason, lost American Specialty Board Certification?		
14. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? ____		
15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
17. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
19. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
20. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. Quebec # 77-182		

NOTE ON QUESTIONS 17-19: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #20 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for American Specialty Board Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: [signature] DATE: July 12th, 1988

88-00806

AFD

THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — $150.00 must accompany APPLICATION — No currency or personal checks)

Filed: 4/7/88
By: JML
Form of Fee: CK

For Office Use

Application # 64040
Certificate # 60491
Date of Issue 10/19/88

Please Print

SWORN STATEMENT

Date: March 11th, 1988.

Name: Alain (First) Lester (Middle) CAMPBELL (Last)

Address:

Date of Birth:

Place of Birth: St-Hyacinthe, Quebec, Canada

Pre-Medical Education

School: University of Montreal

Years Attended: B.Sc. : 1969-72
previously: B.A. (Univ. Mtl, 1969)

Medical Education

School: McGill University

Years Attended: 1972-76 : M.D., C.M.

Postgraduate Education & Hospital Appointments

Place	Position	Dates
McGill Univ.	POSTGRADUATE EDUCATION: M.Sc. (Experimental Medicine - Endocrinology)	1972-1976
	Residency program: OB/GYN: McGill Univ. and Univ. Mtl; 1977-80	
	Appointments: Assistant Prof Clinical OB/GYN, Fac Medicine and Graduate Studies, Univ. Montreal, Ste-Justine and Hôtel-Dieu University Hospitals; 1981-actual 1988;	

List all other states in which you have been fully licensed: QUEBEC, only, Canada : 77-182

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

I never took the Canadian L.M.C.C. or F.R.C.P.C. exams;
This application is for full licence or licence restricted to OB/GYN as I am certified by an American Specialty Board. I have made a commitment to join an OB/GYN practice at Atlantic Care Medical Center, in Lynn, Mass., on July 1st 1988, which is a designated Medically Underserved area in OB/GYN; they are relying on me to begin treating patients on July 1st 1988

Thank you

Alain Campbell M.D.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
FULL LICENSE

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alain L. CAMPBELL

PERMANENT ADDRESS:

LOCAL MAILING ADDRESS IN (MA): ~~1a~~

HOSPITAL: Ste-Justine Hospital

ADDRESS: 3175 CÔTE SAINTE-CATHERINE,
Montreal, Quebec, Canada
H3T 1C5

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.	
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.	
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.	
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.	
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.	
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____, _____.	18.	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: A. L. Campbell DATE: March 11th, 1988

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

2005 MAR 28 PM 2:04 RECEIVED BOARD OF REGISTRATION IN MEDICINE

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: NOT AVAILABLE AT OFFICE

4) Fax Number: 781-592-9625

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

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

List Certifying Board(s) below:			**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
Board Name	**ABMS**	**or AOA**	***Certificate/Subspecialty***	**Correct?**	**Delete?**
AMERICAN BOARD OBSTETRICS GYNECOLOGY	☒	☐	Obstetrics & Gynecology	☒	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)** NONE
a) Massachusetts:	
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)** QUEBEC
c) Federal (DEA) XS:	

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

Principal Work Setting: Private Office Change to: _____

Please enter principal work setting hours per week here: 18-20

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category		# Hours per Week
		Current	Change	
North Shore Medical Center - Salem Hospital	☐	Admitting		0.5
Union Hospital	☐	Admitting		1
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 5 hrs/wk Change to: 1 hrs/wk

b) outpatient care 30 hrs/wk Change to: 18-19 hrs/wk

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

My medical liability insurance is provided through: (check one)

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group I-31022 Change to: _____

Policy dates: From 02/07/05 To 02/07/06 *(required)*

☐ **Letter of Credit subject to Board approval** ***(attach a copy)***

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

Check one:

- ☐ Not involved with direct or indirect patient care in Massachusetts
- ☐ Government Employee Federal Tort Claims Act (FTCA)
- ☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* If Yes, please complete Form PCA-O "Office Based Surgery"	**Yes**	**No**

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

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

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

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

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

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.: 60491**

PHYSICIAN PROFILE

☒ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

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

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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

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

Signature: _____ Date: 03/25/05

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

Dr. Alain Lester Campbell

Data base License Number: 60491

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐

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

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

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

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

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to enclosed Taxonomy Code List). 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:	207V00000X	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): _____ Country of Birth (if outside the US): CANADA

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 number to any authorized hospital, health plan, or health organization.**

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

Signature: M Campbell Date: 02/11/2007

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

Dr. Alain Lester Campbell
9 Boston Street
Suite 9
Lynn, MA 01904-0000

01/25/2007

Dear Colleague:

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

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

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

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

Sincerely,

Martin C. Crane MD

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

9 Boston Street
Suite 9
Lynn, MA 01904-0000

APR 10 2007

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

9 Boston Street
Suite 9
Lynn, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 781-592-9625

Correct your E-mail and Fax Number below:

_____ _____

_____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

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

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

_____

9) States where you were previously licensed

_____

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
North Shore Medical Center - Salem Hospital	SALEM	MA	☐
Union Hospital	LYNN	MA	☐
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 1 hrs/wk Change to: _____ hrs/wk

b) outpatient care 18 hrs/wk Change to: _____ hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 02/07/2007 To 02/07/2008

Type of Policy: ☐ Claims made with tail coverage ☒ Occurrence Policy

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

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

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

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

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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

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

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

PART C

Check One:

PHYSICIAN PROFILE

☒ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

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

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

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

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

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

Signature: _____ Date: 03/23/07

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

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

Dear Colleague:

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

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

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

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

Sincerely,

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

☒ My current NPI is: 1184753360

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207V00000X	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): _____ Country of Birth (if outside the US): CANADA

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 number to any authorized hospital, health plan, or health organization.**

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

Signature: _____ Date: 04/04/07

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

Alain Lester Campbell M.D.
9 Boston Street
Suite 9
Lynn, MA 01904-0000

March 07, 2007

Dear Dr. Campbell:

The Board of Registration in Medicine is the designated repository for National Provider Identifier (NPI) numbers for physicians licensed in Massachusetts. Your NPI number is listed below:

1184753360

Please Note: This letter serves as your official NPI notification. The NPI noted above belongs to the provider listed as the addressee and shall remain with the provider. Please retain a copy of this letter for your records. Medicare requires a copy of this letter if you are a new enrollee or processing any other changes in your Medicare information.

Your NPI number replaces the identifiers you currently use in HIPAA standard transactions with Medicare and other health plans. The Board of Registration in Medicine has your authorization on file to provide your NPI number to any authorized agency, hospital, health plan or health organization.

The Massachusetts Board of Registration in Medicine is the only state medical board providing free services to assist licensees in obtaining an NPI number. We hope that this service has been helpful to you and demonstrates the Board's appreciation for Massachusetts' physicians dedication and service to patients.

Best wishes for your continued success.

Martin Crane, M.D., Chairman
Board of Registration in Medicine

Nancy Achin Audesse, Executive Director
Board of Registration in Medicine

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2009 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
9 Boston Street
Suite 9
Lynn, MA 01904-0000

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

APR 22 2009
Board of Registration in Medicine

2c) BUSINESS ADDRESS
9 Boston Street
Suite 9
Lynn, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 781-592-9625

Correct your E-mail and Fax Number below:
_____
_____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and Gynecology	☐	
	☐	
	☐	

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

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

04/23/03 31 84

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

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
North Shore Medical Center - Salem Hospital			☐
Union Hospital			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 1 hrs/wk Change to: _____ hrs/wk

b) outpatient care 18 hrs/wk Change to: 14 hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 02/07/09 To 02/07/10

Type of Policy: ☐ Claims made with tail coverage ☒ Occurrence Policy

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

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

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

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

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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

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

	YES	NO
14) CLAIMS MADE a) **NEW:** Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

04/23/09 S1

PART C

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

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

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

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

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

Check One: **PHYSICIAN PROFILE**

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

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

Signature: _____ Date: 03/27/2009

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

Current Status: Active **License Expiration Date:** 4/28/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Cardone & Asso Rep Med, 2 Main St
Suite 150
Stoneham
Massachusetts - 02180
United States of America

Home Address:

Business Address:
2 MAIN ST, CARDONE & associates rep med
Suite 150
Stoneham
Massachusetts - 02180
United States of America
(781) 592-3000

3) Email Address:

4) Fax Number: (781) 438-9601

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
New Hampshire

9) States where you were previously licensed
None Reported

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

WorkSite	Location
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 10 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Medical Professional Mutual Ins Co	02/07/2011	02/07/2012	Occurrence Policy

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

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

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

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

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

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

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

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

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

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

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: Alain Lester Campbell, M.D. **License No.:** 60491

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: Alain Lester Campbell, M.D. **License No.:** 60491

Current Status: Active **License Expiration Date:** 4/30/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Cardone & Asso Rep Med, 2 Main St
Suite 150
Stoneham
Massachusetts - 02180
United States of America

Home Address:

Business Address:
2 MAIN ST, CARDONE & associates rep med
Suite 150
Stoneham
Massachusetts - 02180
United States of America
(781) 592-3000

3) Email Address:

4) Fax Number: (781) 438-9601

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
New Hampshire

9) States where you were previously licensed
None Reported

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

WorkSite	Location
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 1 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Other

Lymphoma Chemo Dec Jun 2012 comp including 3 hops Sept. Dec. many days IV abx. Adm asthma Dec, severe neutropenia Ap 23 170 ANC No patient since chemo no wish to retire insurance costly; take when stable Inactive lic long to re-establish.

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?

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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?

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

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 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?

Compliance with Legal Responsibilities

Online profile:

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

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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.

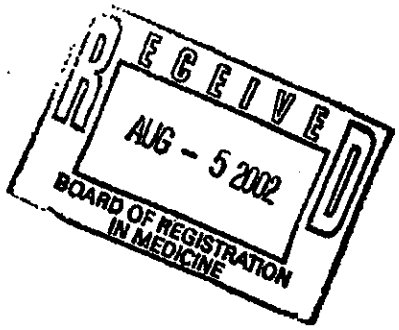
14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

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.**

July 18, 2002



Ms Luz A. Carrion
Paralegal, Clinical Care Unit
Board of Registration in Medicine
Boston, MA

Dear Ms Carrion:

The medical record of is enclosed. You asked for ultrasound films, so I suppose you wonder why there is a discrepancy between my results and the ultra-sound performed elsewhere.

The following comments expressed in quotes come from Williams Obstetrics, the classical textbook of Obstetrics (Williams Obstetrics, Norwalk, CT, Appleton & Lange)

1- Many Ob/Gyn and Hospitals use different tables for fetal measurements, hence different results: "As emphasized by Jeanty (1991), deciding which table(s) to use can be difficult".
2- The choice of the percentile will influence results: "For example, a biparietal diameter of 40mm could represent a fetus of 14 weeks (5th percentile) or 20 weeks (95th percentile) as compared with 17 weeks when the 50th percentile is used." Most clinicians (but not all) will use the 50th percentile.
3- I have had other cases in the office where my ultrasound gave the same results as an ultrasound performed elsewhere.
4- Even with the same table, there is a variation among readers: "Different fetal dimensions have different reliability and ease of measurement at different gestational ages."
5- The exam and ultrasound were

. The diagnosis of twins is often missed, even with ultrasound: "Most contemporary reports on twin gestations where selective (based on indications) ultrasound examinations were performed indicate that about 80 percent of twins are diagnosed before labor using this approach (Andrews and colleagues, 1991; Kovacs and co-workers, 1989). Kemppainen and co-workers (1990) diagnosed three fourths of twins by 21 weeks in over 4600 Helsinki women receiving clinically indicated ultrasound examinations. ... The identification of pregnancy complicated by multiple fetuses is missed not so much because it is unusually difficult but because the examiner fails to keep the possibility in mind." So a fairly large number of twins are missed on clinical grounds.
6- The patient left a Lynn address, so I referred her to an Ob/Gyn in Lynn, , 225 Boston St. (my address is 9 Boston St.). The office was closed when I

called but I left a message for her to be seen the next week for continuity of care. I understand she now gives a New Hampshire address.

7- The subsection "diagnosis of multiple fetuses" in the chapter "Multiple pregnancy" starts in Williams with the following comments: "It is unfortunate that the diagnosis of twins has frequently not been made until late in pregnancy, often as late as the time of labor and delivery."

8- "Before the third trimester, it is difficult to diagnose twins by palpation of fetal parts. It is apparent in Figure 39-9 that even late in pregnancy it may not always be possible to identify twins by transabdominal palpation, especially if one twin overlies the other, ..."

9- "In the case of a woman that appears large for gestational age, the following possibilities are considered: (1) multiple fetuses, (2) elevation of the uterus by a distended bladder, (3) inaccurate menstrual history, (4)hydramnios, (5) hydatidiform mole, (6) uterine myomas or adenomyosis, (7) a closely attached adnexal mass, and (8) fetal macrosomia late in pregnancy."

. Dr. Blass would have investigated her the next week by a complete obstetrical exam of a regular OB patient and the ordering of a complete and thorough detailed ultrasound exam in the hospital.

I believe that I have illustrated my point. I know many surgeons who have removed a normal appendix on a pathology exam but they acted with good faith and do not have to justify themselves at various units of the Board of Registration in Medicine. As well, patients have to pay a fee for the medical service rendered.

I do have medical expenses to run my office and it is perfectly legal to charge patients for a medical visit and physical exam including ultrasound for evaluation of the This is a standard fee in this state. This case is a medical act like any medical act. There will be many months before we know how many weeks she approximately was at the time of the visit but still here, as we are dealing with clinical medicine, there will be a range of weeks. We are dealing with clinical medicine, not mathematics. The BPD (biparietal diameter) found by the other physician is not the gold standard of medicine and I am happy that he/she found the patient is having twins on a complete antenatal ultrasound evaluation for regular obstetrical care.

The report of the ultrasound (U/S) is enclosed in the medical notes, page 8 of the chart of the patient, as is done at and across Massachusetts. Fundal size was 25 cm, corresponding to a normal clinical pregnancy of 24-26 weeks. BPD was estimated at 53-54mm, corresponding to a gestation of 22 weeks. Femur could not be assessed accurately as the fetus was moving too much, so a questionable 44mm, which would be 24 weeks. Again, discrepancies were not analyzed as it was not a case for the office. As you will note, there is no place in the chart for placental location as the U/S is done simply to complement a clinical exam; if appropriate, I write placental location in the chart.

I hope the patient can understand those limitations in the practice of medicine.

Thank you and sincerely yours,

Alain L Campbell, MD, MSc, Diplomate ABOG (1986, recertified 1996)

References:

1- Andrews WW, Leveno KJ, Sherman ML et al: Elective hospitalization in the management of twin pregnancies. Obstet Gynecol 77:826, 1991
2- Kemppaineu AS, Karjalainen O, Ylostalo P, et al: Ultrasound screening and perinatal mortality: Controlled trial of systemic one-stage screening in pregnancy. Lancet 336:387, 1990
3- Kovacs BW, Kirschbaum TH, Paul RH: Twin gestations, I. Antenatal care and complications. Obstet Gynecol 74:313, 1989
4- Jeanty P: fetal biometry. In Fleischer AC, Romero R, Manninf FA, Jeanty PJ, James AE (eds): The principles and Practice of Ultrasonography in Obstetrics and Gynecology, 4th ed. Norwalk, CT, Appleton & Lange, 1991, p 93

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☐ Mrs. Your First Name Your Last Name Patient Name (if different)
☑ Ms.
☐ Mr.

Street Address Mailing Address (if different)

City State Zip Code

Business/Daytime Phone Home Phone

Complaint against M.D. ✓, D.O. ____, Acupuncturist ____.
(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7408, or 239 Causeway St., Boston, MA 02114.)
This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.
Alain Campbell

Address
9 Boston St. Lynn, MA 01905

City State Zip Code
781-592-5622

Business Phone
Alternative Medical Care of MA

Name and Location of Health Care Facility (if known)

Nature of Complaint

☐	Substandard Medical Care	☐	Drug Dealing
☐	Professional Misconduct	☐	Criminal Conviction
☐	Sexual Misconduct	☐	Patient Neglect/Abandonment
☐	Rude or Discourteous Behavior	☐	Unlawful Discrimination
☐	Impaired by Alcohol or Drugs	☐	Billing for Services Not Rendered
☐	Impaired by Mental or Emotional Illness	☐	Failure to Supervise Staff
☐	Failure to Provide Medical Records	☐	False Advertising
☐	Overcharge for Medical Records	☐	Fraud

☑ OTHER incorrect diagnosis on an ultrasound

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: 3/7/02
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

Signature of Patient. _____ Date: 3/7/02
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☐ Yes, ☑ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☑ No

How long have you (or patient) been under this physician's care?
☑ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☐ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☑ Other: boyfriend

Are you (or patient) expected to pay a portion of this bill out of pocket?
☑ Yes, ☐ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☑ No

Is the fee or copayment in dispute?
☑ Yes, ☐ No

Has the physician been contacted about this complaint?
☑ Yes, ☐ No

Dates of Treatment: Friday, 2002

09/03/08 91 93

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

I had gone to Dr. Campbell for [redacted]. Before he even saw me, my boyfriend [redacted] paid him $325 for the service. When they took me in, Dr. Campbell did [redacted]. He claimed that I was 22 to 24 weeks pregnant. He wrote [redacted] a check for $175, charging him $150 for the ultrasound, which was never discussed. I followed up with an obstetricianist who determined by ultrasound that I was not that far along and that I am pregnant with twins. I am very upset that [redacted] paid $150 for false information, so I confronted Dr. Campbell about the situation. He refused to reimburse the money and said that the ultrasound was to determine the stage of my pregnancy and not anything else. It is quite obvious that he did something incorrect to miss that there are two babies and not one. I got nothing but greif from all of this. I shouldn't have to pay for mistakes.

Attach copies of related documents to this form. ultra sound
The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: [redacted] Date: 3/7/02

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111

If he [redacted] did his job the right way something could have been done.

09/30/02 MON 13:34

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

REDACTED COPY

April 3, 2003

Alain Lester Campbell, M.D.
9 Boston Street, Suite 9
Lynn, MA 01904

Re:
Docket No: 03-075

Dear Dr. Campbell:

The Complaint Committee of the Board of Registration in Medicine met on April 2, 2003 and carefully considered the information both you and the complainant furnished in the above-referenced matter. They determined that no further action was warranted and the matter has been closed. Despite the decision to close the above complaint the Board reserves the right to reopen the complaint should you commit any violations of Board statutes or regulations in the future.

If you have any questions regarding this matter, I can be reached at the number or address listed above.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager

KMS\so

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

April 3, 2003

Re: Alain Lester Campbell, M.D.
Docket No: 03-075

Dear

The Complaint Committee of the Board carefully considered the information you furnished regarding your complaint against the physician referenced above. A copy of the complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues that were raised.

After a thorough review of this evidence, the Committee determined that the complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative to you in bringing this matter to its attention.

Should you have any questions I can be reached at the number or address listed above.

Thank you again for your concern.

Very truly yours,

Kathleen M. Shea

Kathleen M. Shea
Consumer Protection Manager

KMS\so

March 06, 2003

Ms Kathleen M. Shea
Consumer Protection Manager
Board of Registration in Medicine
Boston, MA

Dear Ms Shea Re:
Docket Number 03-075

Thank you for your letter, dated February 13, 2003. There is a civil action filed against me by ,on the same allegations, dated August 2002. Her attorney signed himself out of the case recently, due to irreconciliable differences between him and her, so the case is at a standstill for now, the Court having accepted his withdrawal. So I believe she then decided to file a complaint with you.

I do have problems to read her handwriting but the comments are the same. as in the civil action. I am surprised she stayed with me from 1991 to 1999 if she was not satisfied with my approach to her care.

I am sending you a copy of the denial by my attorney (1st defense), as the comments are similar.Please as well refer to the letter that I prepared for the reviewers, dated 10-20-2002.
1st complaint:
Delivery was performed with the usual standard of care, as well as ante-natal care. Gestational diabetes is not an indication for cesarean delivery, neither is a baby 7 pounds 8 ounces.
2nd complaint:
Uterine bleeding was benign and irregular, with no anemia. Problems were diagnosed and treated medically and surgically, with the usual standard of care.
3rd complaint:
I continued to offer medical and surgical treatment of her endometriosis, a chronic and persistent disease, where both medical and surgical treatment offer similar response rates.I refused to perform an elective hysterectomy in her case, as explained in the letter dated 10-20-2002. I told her other gynecologists could opt for an hysterectomy, but I would not perform it myself. Her bleeding could have been controlled by endometrial ablation. I have no notion of a significant fibroid in her case

In summary, she had standard medical care and was treated medically and surgically for her endometriosis and bleeding. She had a normal vaginal delivery for her beautiful daughter.

I believe that if [redacted] sees my answers, it will give her an edge in court against me as the arguments-answers will be the same.
I am thus asking the Board to suppress her right in the actual circumstances to see my answers. She could see them after a Court decision is reached. She could in fact use this complaint as an excuse to have access to my defense pre-trial.

Thank you,

Sincerely yours,

Alain L Campbell, MD, MSc, Diplomate ABOG (1986, recertified 1996)

cc: Esq Charles P Reidy III, Martin, Magnuson, McCarthy & Kenney
101 Merrimac St, Boston, MA 02114; 617-227-3240

RECEIVED
FEB - 7 2003
Board of Registration in Medicine

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☐ Mrs. ☐ Ms. ☐ Mr.	Your First Name	Your Last Name	Patient Name (if different)
Street Address		Mailing Address (if different)	
City	State	Zip Code	
Business/Daytime Phone		Home Phone	

Complaint against M.D. ✓, D.O. ____, Acupuncturist _____.

(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)

This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.
Dr. ALAIN CAMPBELL, GYN

Address

City | State | Zip Code

Business Phone

Name and Location of Health Care Facility (if known)

Nature of Complaint

- ☒ Substandard Medical Care
- ☐ Professional Misconduct
- ☐ Sexual Misconduct
- ☐ Rude or Discourteous Behavior
- ☐ Impaired by Alcohol or Drugs
- ☐ Impaired by Mental or Emotional Illness
- ☐ Failure to Provide Medical Records
- ☐ Overcharge for Medical Records
- ☐ Drug Dealing
- ☐ Criminal Conviction
- ☒ Patient Neglect/Abandonment
- ☐ Unlawful Discrimination
- ☐ Billing for Services Not Rendered
- ☐ Failure to Supervise Staff
- ☐ False Advertising
- ☐ Fraud

☒ OTHER Dr. Campbell neglected my care especially in major troublesome vaginal bleeding pain (hemorrhaging) 1997-1999. I as a result I had emergency [illegible] & lost uterus x both ovaries. [illegible] addressed situation.

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: Feb. 5, 2003
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

Signature of Patient: _____ Date: Feb. 5, 2003
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

Salem Hospital - ER Apt 1 visit to stop bleeding
" " - D&C x numerous biopsies,
Fibroids also removed

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☒ Yes, ☐ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☒ Yes, ☐ No

How long have you (or patient) been under this physician's care?
☐ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☒ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☐ Commercial Insurance, ☒ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other_____

Are you (or patient) expected to pay a portion of this bill out of pocket?
☒ Yes, ☐ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☒ Yes, ☐ No

Is the fee or copayment in dispute?
☐ Yes, ☒ No

Has the physician been contacted about this complaint?
☐ Yes, ☐ No

Dates of Treatment: 1-91 thru 99

09/05/08 09:51 FAX 40 3

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

During my initial meeting of Dr. Campbell it was when I became pregnant. Dr. Linda Jenkins my previous OB/GYN was in process of retiring & Dr. Campbell was taking over her practice.

I feel Dr. Campbell was negligent from the beginning of my care (child birth) On 9/1 I was in labor for approx. 15 hrs. my child was 7lb 8oz and I also was gestational diabetes. I feel my pregnancy & delivery was not monitored On , my daughter Shanel Rose was considered for a C-Section due to I feel my doctor (gynecologist) & size of my baby.

2nd Negligence - diagnosed incorrect hormones to stop my excessive vaginal bleeding/hemorrhaging. I was prescribed Premarin (w/my veins) + Cycrin, when a Pelvic Exam should have been prescribed.

3rd Dr. Campbell said I was pregnant, my estimate in 9/99, I could no longer get my pap smear or stirrups & feet my uterus was swollen to the size of a (23 month) pregnancy & I was NOT pregnant. I could not take I step without hemorrhaging. My P.Care physician then referred me to a Dr. Zolt Mansfield who said on my 1st visit we need to put you in the hospital today to stop the bleeding & hemorrhaging.

Attach copies of related documents to this form.
The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: _____ Date: Feb. 5, 2003

Mail this form to:

Consumer Protection Manager
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, MA 02118

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

January 26, 2005

Alain Lester Campbell, M.D.
9 Boston Street
Suite 9
Lynn, MA 01904-0000

Re:
Docket Number: 05-035

Dear Dr. Campbell:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Your response should be sent to me, at the address above, within thirty days of your receipt of this letter. After your response is received, the case may be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this request.

Very truly yours,

Jennifer A. Brown
Consumer Protection Coordinator

JAB/som

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
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Enforcement Division Fax: (617) 451-9568
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MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

January 26, 2005

Re: Alain Lester Campbell, M.D.
Docket Number: 05-035

Dear

Your complaint regarding the physician named above has been received. The physician involved has been asked to respond in writing to your complaint. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to me at the address above.

Very truly yours,

Jennifer A. Brown
Consumer Protection Coordinator

JAB/som

Commonwealth of Massachusetts

Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

March 14, 2005

Re: Alain Lester Campbell, M.D.
Docket Number: 05-035

Dear

Enclosed please find a copy of Dr. Campbell's response. You will be notified when there is a disposition in this matter.

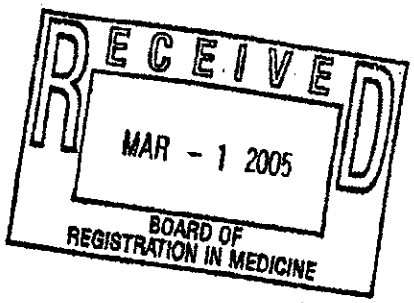
In the meantime if you have any questions, I can be reached at (617) 654-9800 ext. 4033

Very truly yours,

Jennifer A. Brown
Consumer Protection Manager

JAB/bmh
Enclosure

February 23, 2005



Ms Jennifer A. Brown
Consumer Protection Coordinator
Board of Registration in Medicine
Boston, MA

Dear Ms Brown: Re: , 05-035

Thank you for your letter dated 01-26-2005, post marked 01-27-05 and received 02-01-05 (office is closed on Monday, weekend in between).

As you indicated in your letter, my answer may be as brief or as lengthy as I choose.

The nature of the complaint involves 5 main items: substandard medical care, professional misconduct, rude or discourteous behavior, patient neglect/abandonment, unlawful discrimination. These complaints imply a patient- physician relationship.

I could terminate my letter here stating that a patient-physician relationship was never established. Thus the complaints are rejected. She came for an . In fact, we did not even review her medical history.

Women can choose their physician, likewise, physicians can choose their patients for an elective procedure.

However, with respect for the Board of Medicine, who has to answer to all letters they receive, I will make some comments.

As quoted by Joanne Tetrault, MA, with Joan Roediger, JD, LLM in Physicians Practice, January 2005: Severing the ties, how to end a patient relationship legally (p.73):

"to establish a physician-patient relationship, both parties must voluntarily consent to it, and the physician must indicate an intention to treat the patient."

I refused to see as a patient for an elective termination of pregnancy.

All of her comments in this letter were negative.

If all the experiences were negative, the Board would be inundated, monthly, with letters of complaints that I could not defend. I am a board certified obstetrician-gynecologist, I still practice general gynecology and my patients are happy.

I will make comments in the order of the facts that she is referring to. The secretary was absent that day. The nurse and myself decided we would see the potential candidates ourselves. was part of a group of three different people who arrived late and at the same time.

I am registered at City Hall in Lynn as Alain Campbell, MD, DBA Atlanticare Ob/Gyn and Alternative Medical Care. I function as an individual, not a clinic. This is my private office where I see established general gynecology patients

My waiting room was completely rebuilt around 1 ½ years ago, following water damage. It is modern and clean. I understand that it may not have the nice appearance of some of the buildings in Cambridge, where lives. Many of my patients come from Lynn, Lawrence and Lowell. These are poor areas, but people have a right to be treated no matter where they live. People may have more of a tendency to let advertisement tags in magazines drop to the floor, without picking them up so we do clean more often, after office hours. There are, at times, children playing on the ground, as some of these customers have no money to pay for a baby sitter. I do not know if there were children the day she came. I enclose a digital picture of the waiting room.

A private medical office is not an airport: people do not have to show a picture identification. Verification of age is not necessary unless the woman appears young. In such a case, it will be done in room #1, privately by the nurse or the nurse-assistant, not in front of everybody. This is a standard medical practice. When people schedule an appointment, different forms of payment are discussed. Insurance data do not belong on the consent form.

, they will sign directly on the insurance form (HCFA-1500) that I explain myself just before the surgery, when I review the medical chart. A social security number is not mandatory on this form. As you can see, many of her comments come from her ignorance of the medical technicalities of the daily practice of medicine.

Her comments about being asked no questions about her name, background, age, health is irrelevant as that information was supplied by her in the chart. but we never got to that point as I refused to see her as a patient.

told she had questions for the doctor, so she bypassed room #1 (where a first screening is usually done by the nurse or nurse-assistant) and she came directly into the procedure room.

The "makeshift recovery room", as calls it, was actually decorated by a 3rd year student of Architecture. It is clean and simple. I admit it does not compare to some of the Cambridge clinics or surgicenters. Digital pictures are enclosed.

The "broken down chair" is actually a lounger that can be reclined into a bed-like position, so that patients are more comfortable. I have two of these. The blood pressure was beeing taken by a wrist digital BP cuff, which she probably never saw before.

The procedure room is clean. The ultra-sound machine is older but still very functional. Cleaning is done regularly and the usual garbage can is emptied many times a day. As per law, there are red containers labeled for disposal of needles, syringes, and spoiled biologic materials, which are picked up by Stericycle (as I am part of the Partners Health Care Group through hospital affiliations). There is no hair on the floor, but people walk in and out, and wear boots in the winter. We do clean the floor in between customers. The "dirt stains" as calls them, are surgical scrub (Iodine), which stains the tiles permanently.

I am enclosing a copy of the chart and consent forms she completed. As you can see,

Compare them to the state form enclosed. They were developed by an attorney and more than three gynecologists. When women have questions, I always refer to the consent forms, because they are very comprehensive, and I answer any additional questions they may have. I answered questions about infection, and told her about my estimates of risks, which are lower than those on the consent form. I told her the surgery was considered minor, and she should be fine the next day to go to work. She asked me about infertility risks.

Everybody receives antibiotics, but there is always a small group of infertile women, and it is a possibility that she could be part of them.

This is when partner asked me if I had any history of malpractice suits (he did not ask me if my history was above normal, as suggested by complaint letter- witness present). I answered yes. I have a limited history of malpractice suits. I told him I did not wish to discuss malpractice suits, as they are already reported with the Board of Medicine, the insurance plans, and the 2 hospitals that I am affiliated with. I told her there were potential complications associated and given her great concerns, I did not want her to be my patient. I let her know she should not have her surgery in a private office but rather in the hospital. Scientific data show no difference in outcome between in the office and hospital settings. In the past two decades, were performed in office settings, not in hospitals or surgicenters. I told to " please dress and leave the office, and call ", where we refer.

My "hands incrusted with white paste" are powder residue from the gloves I had just removed before seeing her (no infectious material handled), and from the repeated hand washing throughout the day. As is the case with all physicians, I obviously do take a bath daily and clean my nails. I wash my hands in between patients and clean the nails (medical students are taught early to do so). I do not wear gloves when I speak to a woman or review her medical chart (letter suggest it was a mistake not to do so).

Her medical history, that I did not review with her, shows a history of active depression.

was upset that I refused to enter a physician-patient relationship with her, hence a negative letter to the Board of Medicine.

As said earlier, a woman can choose her physician. Likewise physicians can choose their patients for an elective pregnancy termination. As a physician, I cannot be forced to when the woman appears greatly concerned of potential complications or unsure . As well, patients with potential risks, physical or psychological, are not good candidates for office surgery.

Very truly yours,

MD

Alain Campbell, MD, MSc, Diplomate ABOG

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☐ Mrs. ☒ Ms. ☐ Mr. Your First Name Your Last Name Patient Name (if different)

Street Address Mailing Address (if different)

City State Zip Code

Business/Daytime Phone Home Phone

Complaint against M.D. X, D.O. ____, Acupuncturist ____.
(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)
This complaint cannot be processed without the **full** name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.

Alain L. Campbell M.D.

Address
9 Boston St. Suite 9

City State Zip Code
Lynn MA 01904

Business Phone 781 592 3000

Name and Location of Health Care Facility (if known)
d/b/a Atlanticare OBGYN and/or Alternative Medical Care

Nature of Complaint

☒	Substandard Medical Care	☐	Drug Dealing
☒	Professional Misconduct	☐	Criminal Conviction
☐	Sexual Misconduct	☒	Patient Neglect/Abandonment
☒	Rude or Discourteous Behavior	☒	Unlawful Discrimination
☐	Impaired by Alcohol or Drugs	☐	Billing for Services Not Rendered
☐	Impaired by Mental or Emotional Illness	☐	Failure to Supervise Staff
☐	Failure to Provide Medical Records	☐	False Advertising
☐	Overcharge for Medical Records	☐	Fraud

☐OTHER Dirty clinic. Failure to demand identification. Failure to answer questions. (See attached statement)

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient _____ Date: 1/15/2005
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

Signature of Patient: _____ Date: _____
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

Alain L. Campbell, M.D.
9 Boston St. Suite 9
Lynn, MA 01904

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☐ Yes, ☒ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☒ No

How long have you (or patient) been under this physician's care? – I did not end up being treated.
☒ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☐ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other_____

Are you (or patient) expected to pay a portion of this bill out of pocket?
☐ Yes, ☐ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☐ No

Is the fee or copayment in dispute?
☐ Yes, ☐ No

Has the physician been contacted about this complaint?
☐ Yes, ☒ No

Dates of Treatment: 2005

09/02/08 SI 52

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

please see attached statement. thank you

Attach copies of related documents to this form.
The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: _____ Date: 1/15/2004

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
560 Harrison Ave Suite G-4
Boston MA 02118

I waited unto 4:50 when I was finally called in to a backroom. I was asked no questions about my name, my background, my age or my health. I was not given any counseling about the procedure.

As I walked into the OR I noticed the patient who had gone in before me slumped over a broken down easy chair in a makeshift hallway "recovery-room" monitoring her blood pressure. I was taken to the O.R. with my partner and told by nurse to get wrapped in a tissue gown. I said that I would like to ask the doctor a few questions before the . She said, fine, he would be right in. As I waited I put on my gown and noticed that the O.R. was filthy – there was dust on all the equipment, and the countertop. The floor had dirt stains on in the center of the room (around the table) and the outskirts were dirty with bits of dust, hairs and debris. Also it was very crowded and there was broken-seeming equipment lying around. The garbage can was overflowing.

Dr. Campbell came in and introduced himself. He said that he had called my insurance agent himself and that I was covered. He said, "Let's begin." I said I had a couple questions. First I asked about the risk of infection and/or complication and also about what recovery would be like. He said he did not need to answer my questions since all pertinent information was included in the consent forms I had already signed. I noticed while he was talking that his hands encrusted with white paste and his nails were dirty. He was not wearing gloves (though hopefully he would have put them on later). I persisted and said I really would like to know more about risks and also whether or not he had had a higher or lower than normal rate of complications from this procedure. Dr. Campbell would not answer my question beyond directing me to the papers to read.

My partner then said, "Dr. Campbell, if you won't talk about risks, can I ask you if you've had greater than normal problem with malpractice."

Dr, Campbell looked very upset. He turned to me and said, "That's it. I won't speak about this any more and you will not be my patient. I won't take a risk on somebody like you. . Get your things, put on your pants and get out of this office immediately!" Dr. Campbell then stormed out of the O.R. I scrambled to get on my pants and left the clinic.