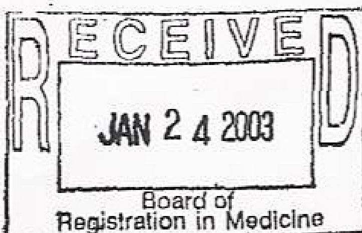


Application #: 216743
Date of Issue:

✓ # 913
600.
CH

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

FULL LICENSE APPLICATION

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

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

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

CARR ELLIS SACHEEN

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

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree ____ ☐ Male ☒ Female

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

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

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

Place of Birth: New York (City) ~~Bronx~~ New York (State/Province/Territory) Country if not USA

Home Address: ____ (Number and Street)

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

Business Address: 1901 1st Avenue (Number and Street)

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

Business Telephone: (212) 423-6796, ext. ____ Home Telephone: ____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

Rec'd ck # 913
amt. 600.00
SN 1/31/03

Pre-medical School

Facility: Union College Degree: BS From 9/ /91 To 6/ /95
Street: 807 Union Street City: Schenectady State: NY

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Medical School

Facility: Albany Medical College Degree: MD From 9/ /95 To 5/ /99
Street: 47 New Scotland Ave City: Albany State: NY

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Date of medical school graduation: 6 / 14 / 99.

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

Postgraduate Education:

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

From To

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

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

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

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

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

PRINT NAME: Sacheen Carr-Ellis

Hospital Affiliations and Employment

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

		From	To
Facility: Metropolitan Hospital	Position: Resident	7/1/99	6/30/01
Street: 1901 1st Avenue	City: NY	State: NY	
Facility: Westchester Medical Center	Position: Resident	7/1/01	6/30/03
Street: Grasslands Ave.	City: Valhalla	State: NY	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

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

   ______ Certification date: __/__/__
4. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Employment
6. Name of Facility: Boston Medical Center
7. Address: 91 E Concord St FL 3 City: Boston Mass
8. *Anticipated starting date in Massachusetts:* 7 / / 03

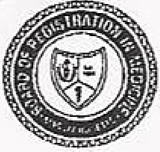
Affidavit of Applicant

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

Signature of Applicant

1/21/02
Date

Rev: 10/21/2002



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

Physician Registration Renewal Application

0001040009391 74

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 at least 4 weeks before your renewal date.*

- **Remit $400.00 for renewal fee (non-refundable).**
- **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. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.:216743 Renewal Date:04/02/2004

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:

A) Mailing/Business Address:

3. Sacheen Carr Ellis

MAR - 1 2004

B) Home Address:

Home Phone:

Business Phone: (718)601-9693

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

Mailing Address: 85 East Concord St. 6th Floor
City/Town: Boston State: MA
Zip: 02116 Country: U.S.

Business Address: Same as above
City/Town: State:
Zip: Country:
Business Telephone: ( )

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

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

4. a) Date of Birth: b) Sex: F
 c) SS#:

5. a) Name of Medical School: Albany Medical College of Union University
 b) Year Graduated: 1999 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.
OBG	0 50
	0

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

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

9. a) Other states where you are now licensed to practice (Abbr.)
 N Y
 b) States where you were previously licensed (Abbr.)

10. List all current health care facilities at which you are affiliated or 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). ___ No affiliations.

Facility Code: 530 / ___ (AP) 100 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): ___

PRINT YOUR LAST NAME: Carr-Ellis LICENSE NUMBER: 216743

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

Insurer's name. (Required): Boston Medical Center Ins. Co. Policy dates: From: 06/30/03 To: 06/30/04

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 in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: ______

12. What is your principal work setting? (See Table 4) 10 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).
    1) Average weekly hours involved in: A) inpatient care 25 hrs/wk B) outpatient care 25 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

Question	YES	NO
14. **CLAIMS MADE (New or Pending):** 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?		
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. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 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, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: [signature] Date: 2/20/2004

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.

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis **License No.: 216743**

PART A

1) Current Status: Active **Renewal Due Date:** 03/05/2006 **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.

RECEIVED
JAN 04 2006
Board of Registration in Medicine

RECEIVED
JAN 23 2006
Board of Registration in Medicine

2a) MAILING ADDRESS
85 East Concord Street
6th Floor
Boston, MA 02116

☐ *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
85 East Concord St.
6th Floor
Boston, MA 02116

Phone: (718)601-9693

☐ *Check here to change this address*

Business Address: 850 Harrison Ave 4th floor
City/Town: Boston State: MA
Zip: 02118 Country: USA
Business Telephone: (617)414-4893

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 617 414-7300

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?**
Written OB/GYN Boards,		Currently Board eligible.	☐	☐
OB/GYN Boards	to be	taken in 2006	☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis **License No.:** 216743

(See Renewal Instructions, page 4.)
7) Drug License Numbers, if any:
a) Massachusetts:
b) Federal (DEA):
c) Federal (DEA) XS:

Please make corrections as necessary
8a) Other states where you are now licensed to practice (Abbr.)
NY
8b) States where you were previously licensed (Abbr.)

9) What is your principal work setting? *(See Renewal Instructions, page 4.)*
Principal Work Setting: Hospital Change to: ____________
Please enter the *approximate* number of work hours at your principal work setting: 50

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 ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Boston Medical Center	☐	Active		50
Planned Parenthood	☐	Active		7
	☐			
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 25 hrs/wk Change to: ____ hrs/wk
b) outpatient care 25 hrs/wk Change to: ____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*
My medical liability insurance is provided through: (check one)

☒ **Insurance Carrier** ***(complete below)***
Current Insurance Carrier: Boston Medical Ctr Ins. Change to: ____________
Policy dates: From 06/30/05 To 06/30/06
(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: Sacheen Carr Ellis **License No.: 216743**

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

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

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

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

22) **CME CERTIFICATION:**

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis **License No.: 216743**

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: [signature] Date: 12 / 21 /2008

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

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis, M.D. **License No.:** 216743

01/29/08 S1 18

PART A

1) **Current Status:** Active **Renewal Due Date:** 03/05/2008 **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
850 Harrison Avenue
4th Floor
Boston, MA 02118

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: 85 E. Concord St.
City/Town: BOSTON State: MA
Zip: 02118 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

RECEIVED
JAN 28 2008
Board of Registration in Medicine

2c) BUSINESS ADDRESS
850 Harrison Avenue
4th Floor
Boston, MA 02118

Phone: (617)414-4893

☐ *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: (617) 414-7300

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: Board Name	ABMS or AOA	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required. Certificate/Subspecialty	Delete?
			☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis, M.D. **License No.: 216743**

(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

NY

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?
Boston Medical Center	BOSTON	MA	☐
Planned Parenthood League of Mass	Boston	MA	☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 25 hrs/wk Change to: ____ hrs/wk

b) outpatient care 25 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: Boston Medical Ctr Ins. Change to: ______

Policy dates: From 06/30/07 To 06/30/08

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: Sacheen Carr Ellis, M.D. **License No.:** 216743

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.

Question	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: Sacheen Carr Ellis, M.D. **License No.: 216743**

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: 1 /23 /2008

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.