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

Physician Registration Renewal Application

COMPLETED

RECEIVED
JUN 27 2001
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. This completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

- **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.

REDACTED COPY

1. Current Status: Active Registration No.: 58220 Renewal Date: 07/05/2001

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:
MARTHA E KATZ
HARVARD MEDICAL SCHOOL
164 LONGWOOD AVE #310
BOSTON, MA 02115-5701

B) Home Address:

Home Phone:

Business Phone: (617)971-2100

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: (_____) _____

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: F

c) SS#:

5. a) Name of Medical School:

b) Year Graduated: 1979 c) Degree: M.D.

Columbia Univ. College of Physicians & Surgeons

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

Code(s)	Hours per Week in Mass.	
FP	0	Family Practice
IM	0	Internal Medicine

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

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

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: 139 / ___ (AP) 50 % Facility Code: 441 / ✓ (AP) 0 % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 921 / ✓ (AP) 5 % Facility Code: 413 / ✓ (AP) 45 % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: KATZ LICENSE NUMBER: 58220

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

Name of Insurer: CRICO = Controlled Risk Insurance Company of Vermont Inc 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) 10

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

1) Average weekly hours involved in: a) outpatient care 95 hrs/wk b) inpatient care 5 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 90 %

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: 6/25/01

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.

AC

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.

- **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**

RECEIVED JUN 11 1999 Board of Registration in Medicine

Registration No.: 58220 Renewal Date: 07/05/1999 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/Business Address:
MARTHA E KATZ, M.D.
HARVARD MEDICAL SCHOOL
164 LONGWOOD AVE #310
BOSTON, MA 02115-5701

B) Home Address:

Home Phone:
Business Phone: (617)432-0431

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

5. A) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
B) Year Graduated: 1979 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
~~FP~~	~~10~~	~~Family Practice~~
IM	25	Internal Medicine

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: FP 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 previously were licensed to practice
Abbr: NY

Please make 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
SS#: __ __ __ - __ __ - __ __ __ __

Full Name of Medical School:
_____
_____
Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
IM	45 hours
If OS, Print Specialty:	_____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

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

♻

PRINT NAME AND NUMBER: Last Name: KATZ Registration Number: 58220

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: 139 / ✓ (AP) 95 % Facility Code: 441 / ✓ (AP) 0 % Facility Code: ___ / ___ (AP) ___ %

Facility Code: 921 / ✓ (AP) 2 % Facility Code: 413 / ___ (AP) 3 % 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: CRICO 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 0

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

1) Average weekly hours involved in: a) outpatient care 23 hrs/wk b) inpatient care 2 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 90 %

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) ☐ 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. 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: Marcia Ellen Katz Date: 6 / 7 / 99

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

CAM 5/23

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.: 58220 Renewal Date: 07/05/97

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/Business Address:
MARTHA E KATZ, M.D.
HARVARD MEDICAL SCHOOL
~~200~~ LONGWOOD AVENUE
BOSTON, MA 02115-5701

B) Home Address:
~~HARVARD MEDICAL SCHOOL~~
~~200 LONGWOOD AVENUE~~
~~BOSTON, MA 02115-5701~~

Home Phone:
Business Phone: (617)432-0431

4. A) Date of Birth:
B) Lic. Issue Date: 08/19/87
C) Sex: F
D) SS#:

5. A) Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
B) Year Graduated: 79 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
FP	10	Family Practice
IM	10	Internal Medicine

7. Current American Board of Medical Specialties Certification (See Table 2)
Code: FP 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 previously were licensed to practice
Abbr: NY

Corrections (type or print)

Other Name(s): _____

Mailing Address: 164 LONGWOOD #310
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.
___ ___ ___	_____
___ ___ ___	_____

If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

(LL)

PRINT NAME AND NUMBER: Last Name: KATZ Registration Number: 58220

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: 139 /__(AP) Facility Code: 069 /__(AP) Facility Code: ____/__(AP)
Facility Code: 921 /__(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) X Insurance Carrier ___b) Letter of Credit
Name of Insurer: CRICO

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) 10

B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 18 hrs/wk b) inpatient care 2 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care ? 100 %

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: 5/9/97

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
58220	ACTIVE	$250.00	07/05/95	$25.00

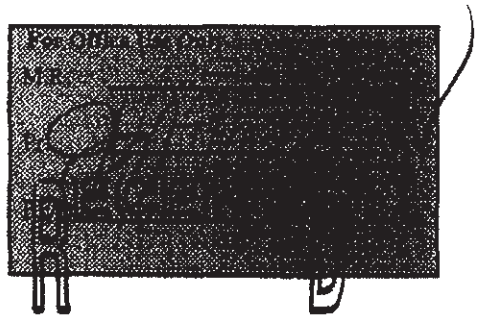
Mailing Address:
MARTHA E KATZ, M.D.
HARVARD MEDICAL SCHOOL
200 LONGWOOD AVENUE
BOSTON, MA 02115-5701

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.



BOARD OF REGISTRATION

Pre-Printed Information

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

2. Business Address:
MARTHA ELIOT HEALTH CTR
33 BICKFORD STREET
JAMAICA PLAIN, MA 02130

3. Date of Birth: Sex: F
Lic. Issue Date: 08/19/87 SS#:

Home Phone Business Phone
(617)522-5300

4. Name of Medical School:
Columbia Univ. College of Physicians & Surgeons
Year Graduated: 79 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr):
b) States where you previously were licensed to practice (Abbr): NY

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

Code	Hours per Week in Mass.	
FP	10	Family Practice
IM	10	Internal Medicine

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

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

Corrections of Pre-Printed Information

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

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

Home: ( ) unlisted Business: ( ) _____

Full Name of Medical School: _____
_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

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

If OS, print specialty: _____

Code: _____ Code: _____

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: Katz Registration Number: 58220

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: 1 3 9 / X (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: 9 2 1 / X (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 ___ (b) Letter of Credit ___ If applicable, check one.

List Insurer: CRICO

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) 1 0

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? 18 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 2 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 100 %

*Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on* 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: Martha Ell Date: 6/20/95

I. PHYSICIAN INFORMATION

MARTHA | E | KATZ
First Name | *Middle Initial* | *Last Name* | *Suffix*

Make changes to name here

Mass License # 58220
License Status Active

First Issue Date 08/19/87

Hospital Affiliation

Martha Eliot Health Ctr.
33 Bickford Street
Jamaica Plain, MA 02130
U.S.A.
(617) 522-5300 X211

Brigham & Women's Hospital
Children's Hospital

Make address corrections here:
Harvard Medical School
200 Longwood Ave.
Boston, MA 02115
USA
(617) 432-0431

Make any corrections to above here:

Insurance Plan Affiliation:
Blue Cross/Blue Shield of Mass.
Tufts Associated Health Plans
Pilgrim Independent Practice Association
Harvard Community Health Plan

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? [X] Yes [ ] No
Accept Medicaid? [X] Yes [ ] No

II. EDUCATION & TRAINING

Columbia Univ. College of Physicians & Surgeons | MD | 79
Medical School | *Degree* | *Date*

Make corrections here

Residency Program(s) *Start* *End*

Residency Program(s) *Start* *End*

Residency Program(s) *Start* *End*

III. SPECIALTY

Primary Specialty: Family Practice

Secondary Specialty: Internal Medicine

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Family Practice

Certifying Board Name:

Make any corrections here:

Recertified 1989, 1995

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action
NONE		

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action
NONE		

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

NONE

VII. MALPRACTICE

Details of claims paid for Dr. KATZ NONE

No. of Years in Practice: # 17

Date	Amount Paid	Basis for Complaint
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

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

Katz ME, Gavin K, Hessner S: Notes from the Field: The Women's Health Program at Columbia University. Am J Public Health, 1987; 77:1352-1353.

Hass S, Acker D, Donahue C, Katz M. Variation in hysterectomy rates across small geographic areas of Massachusetts. Am J Obstet Gynecol 1993; 169:150-4.

Katz, ME, Holmes MD, Power KL, Wise PH. Mortality Rates among 15-44 year old Women in Boston:Looking beyond Reproductive Status. Am J Public Health 1995;85.

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
53220	ACTIVE	$250.00	07/05/93	$25.00

Mailing Address:
MARTHA E KATZ, 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. JUN 24 1993
Pr. FP JUN 24 1993
Bk/D.E. 6-24-93 tn

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   MARTHA ELIOT HEALTH CTR
   33 BICKFORD STREET
   JAMAICA PLAIN, MA 02130

3. Date of Birth: Sex: F
   Lic. Issue Date: 08/19/87 SS#:
   Telephone Number:
   Home Business
   (617)522-5300

4. Name of Medical School:
   Columbia Univ. College of Physicians & Surgeons
   Year Graduated: 79 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): NY
   b) States where you previously were licensed to practice (Abbr):

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

Code	Hours per Week in Mass.	
FP	0	Family Practice
IM	0	Internal Medicine

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: FP Code: IM

   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): _____

none
NY

Code	Hours per Week in Mass.
	10
	10

If OS, print specialty: _____

Code: FP 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: Katz Registration Number: 58220

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: CRICO

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: 1 3 9 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: 9 2 1 / 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) 2 5

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? 14 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 2 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: Marian Katz Date: 6/21/93

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

Registration No.	Status	Fee	Renewal Date
56220	ACTIVE	$150	07/05/91

Dr. MARTHA E KATZ

ENTERED 9/[illegible]

For Office Use Only

M.R. ____ ____/____/____
Pr. ____ ____/____/____
Bk. ____ ____/____/____
Ch. ____ ____/____/____
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 X Inactive ____

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

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

Name: ____

2. a) Address (Home):

Address: ____
City/Town ____
State: ____ Zip: ____
Country Code: ____ (If 999 write Country): ____

2. b) Address (Business):

MARTHA ELIOT HEALTH CTR
33 WICKFORD STREET
JAMAICA PLAIN, MA 02130-

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

3. Date of Birth Sex: F
Lic. Issue Date: 08/19/87 SSN #
Telephone Number:
Home Business
(617)522-5300

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

4. Medical School Code: NY001 Year Graduated: 79 Degree: MD
Name of School:
Columbia Univ. College of Physicians & Surgeons

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

5. a) Other States where you are now licensed to practice (*Abbr*): NY
b) States where you previously were licensed to practice (*Abbr*):

(none)
N Y

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

Code	Hours per Week in Mass.	
FP	0	Family Practice
IM	0	Internal Medicine

Code	Hours per Week in Mass.
____	15
____	15

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:
Code: FP Board of Family Practice
Code: ~~IM Board of Internal Medicine~~ 8

Code: Y
Code: N

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 X 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: ____/____/____]

FILL IN NAME AND NUMBER:

Physician Last Name: KATZ Registration No.: 58220

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

List Insurer: CRICO

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: 921 /✓(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

Facility Code: 139 /__(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: 999 Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s): ST. LUKES - ROOSEVELT HOSP, NY, NY

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✓ (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? 30 hrs./wk. in MA.
   b) How many hours per typical week are you currently involved in *inpatient* care in MA? 1 hrs./wk. in MA.

14. Principal Work Setting.
   a) What is your principal work setting? (*See Table 6*) 25

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: Allen Katz Date 6/28/91

BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC SEC. NUMBER, OPTIONAL ___-___-____

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☐

PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD		58220	$100		7	5	87	

Martha E Katz MD.

NOTE! **THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.**

PAYABLE TO:
COMMONWEALTH OF
MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: Martha E Katz
2. Date of Birth: ___ (MONTH) ___ (DAY) ___ (YEAR)
3. Medical School: Coll of Physicians + Surgeons M.D.? ☒ D.O.? ☐ (Check One.)
4. Country where Medical School located: NY
5. Date of Graduation: 1979
6. American Specialty Board Certified? ☒ (Check if yes.)
   Which Boards? Family Med
7. Principal Specialty(ies): ___
8. Principal work setting: ___
9. Home address: ___
10. Principal business address: ___
11. List all hospitals at which you have currently effective privileges: ___
12. List all hospitals at which you have held privileges in the past 20 years: ___
13. States other than Massachusetts in which you are presently licensed to practice: ___
14. List any other states where you were previously licensed to practice: NY

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. 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)?		
18. 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?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever 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 ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: ___

26. I am an active ☐ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, 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, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

___
SIGNATURE

DATE: ___

(See Reverse Side)

SUPPLEMENT TO APPLICATION FOR FULL LICENSE

Pending ___ Approved ___
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: MARTHA ELLEN KATZ

PERMANENT ADDRESS: _____

LOCAL MAILING ADDRESS IN (MA): _____

HOSPITAL: _____

ADDRESS: _____

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. NEW YORK, _____, _____, _____.	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: Martha Ellen Katz DATE: 7 August 1987

Barnard College
Columbia University
3009 Broadway
New York, New York 10027-6598

Office of the Dean of Studies

July 31, 1987

To the Massachusetts Board of Registration in Medicine:

This is to verify that MARTHA ELLEN KATZ, M.D. completed at least two years of collegiate work as an undergraduate at Barnard College. In fact she completed four years of collegiate work here and received her B.A. degree in May, 1974. She later attended Columbia University for one year to fulfill her premedical science requirements. Our office handled her premedical files and found everything to be satisfactory.

Yours Truly,

Esther Rowland
Dean for Pre-Professional Students

BARNARD

MARTHA ELLEN KATZ, M.D.

Columbia University Health Service
New York, New York 10027
(212) 280-3404

Education

9/67 - 6/71	Barnard College New York, N.Y.	BA, 1974
9/73 - 8/74	School of General Studies Columbia University, New York, N.Y.	
9/74 - 8/75	Institute of Human Nutrition Columbia University, New York, N.Y.	
9/75 - 6/79	College of Physicians and Surgeons Columbia University, New York, N.Y.	MD, 1979
7/79 - 6/82	Residency Program in Social Medicine Department of Family Medicine Montefiore Hospital Bronx, N.Y.	

Fellowship

2/82	Maternal and Child Nutrition Chapel Hill, N.C.

Employment

7/85 - present	Assistant Director for Women's Health Columbia University Health Service, New York, N.Y.
7/83 - 6/85	Assistant Director Columbia University Health Service
6/82 - 6/83	Attending Physician Columbia University Health Service
7/79 - 6/82	Housestaff Montefiore Hospital, Bronx, N.Y.

Licensure Physician, New York State #142908

Certification Family Medicine, 1983

Attending Privileges

Department of Pediatrics,
St. Luke's-Roosevelt Hospital Center, New York, N.Y.

Academic Appointment

Instructor in Clinical Pediatrics,
Columbia University College of Physicians and Surgeons

Teaching

Guest Faculty, Women's Health Care Nurse Practitioner Program, State University of New York, Downstate Medical Center, Margaret Sanger Center, New York, N.Y.

Professional Publication

Katz, Martha Ellen, Kathleen Gavin, and Susan Hessner: The Women's Health Program at Columbia University. "Notes from the Field," Am. J. Public Health, in press, 1987.

Professional Societies

American Academy of Family Physicians
American Public Health Association
Society for Adolescent Medicine

Community Service

1986 - present Collaborator, Alcohol Information Committee, Woman to Woman Program. The Junior League of the City of New York.

1984 - 1985 Women's Counseling Project
Board of Directors

Non-physician Employment

6/74 - present Writer, popular publications: medical education, food and nutrition

2/75 - 9/79 Radio Producer, WBAI-FM, New York, N.Y.
Health Programming

9/73 - 8/75 Research Assistant
Department of Biochemistry
Columbia University

9/71 - 6/73 Environmental Education Director
Hudson River Sloop Clearwater
Poughkeepsie, N.Y.

Popular Publications

Stories of a Woman Learning Medicine,
Doubleday, 1987.

The Complete Book of High-Protein Baking,
Ballantine, Random House, 1975.

Weekly column, New York Post, 1978 - 1979.

Languages French, Spanish

BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOCIAL SECURITY NUMBER (OPTIONAL) [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ]

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE TIONS BELOW AND ON THE REVERSE SIDE OF APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS THROUGH 24, YOU MUST CHECK THIS BOX ☐
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD			$100		7	5		

Martha E Katz, MD.

NOTE! **THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.**

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: Martha E Katz
2. Date of Birth: ___ MONTH ___ DAY ___ YEAR
3. Medical School: College of Phy+Surgeons Columbia Univ. M.D.? ☒ D.O.? ☐ (Check One.)
4. Country where Medical School located: NY
5. Date of Graduation:
6. American Specialty Board Certified? ☒ (Check if yes.)
   Which Boards? Family Med
7. Principal Specialty(ies):
8. Principal work setting:
9. Home address:
10. Principal business address:
11. List all hospitals at which you have currently effective privileges:
12. List all hospitals at which you have held privileges in the past 20 years:
13. States other than Massachusetts in which you are presently licensed to practice:
14. List any other states where you were previously licensed to practice: NY

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. 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)?		
18. 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?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever 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 ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows:
26. I am an active ☐ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, 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, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

SIGNATURE

DATE:

(See Reverse Side)

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.

Martha Ellen Katz . M.D.
(signature)

NAME: MARTHA ELLEN KATZ

ADDRESS: _____

_____

My license number is: 142908

(DO NOT DETACH)

State of: _____

Full Name of Licensee: _____

Graduate of: _____

License No.: _____ Issued date: _____

By: Endorsement/Reciprocity with _____

By: Your State Board's Written Examination _____

License is current? _____ if NO, Why Not? _____

Has license been suspended or revoked? _____ If YES; Why? _____

_____

Has licentiate ever been on probation? _____ If YES, Why? _____

Has license ever been requested to appear before your Board? _____

If YES, Why? _____

Derogatory information, if any _____

Comments, if any _____

_____

Signed: _____

Title: _____

BOARD SEAL

State Board: _____

Date: _____

A/I 5- 8-7-87

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved:
Disapproved:

Application for Endorsement Registration - NATIONAL BOARDS
(Fee- $150. must accompany APPLICATION - No currency or personal checks)

Filed: 8/10/87
By: KF
Form of Fee: M.O.

FOR OFFICE USE

Application # 63036
Certificate # 58220 Date of Issue: 8/19/87

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name MARTHA ELLEN KATZ
First Middle Last

Date of Birth

Place of Birth New York, New York

Name on Birth Certificate Martha Ellen Katz

Mailing Address:

Phone #

Pre-medical Education

School Barnard College ; Sch of Gen'l Studies, Columbia Univ

Dates Attended 9/67-6/71 ; 9/73-8/74

Medical Education

School College of Physicians & Surgeons, Columbia University

Dates Attended 9/75 - 6/79

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

Place	Position	Dates
Residency Program in Social Medicine, Dept of Family Medicine, Montefiore Hosp, Bronx, NY	Resident	7/79 - 6/82
Department of Pediatrics, St. Luke's-Roosevelt Hosp Center, New York, NY	Jr. Assist. Attending	7/82 - present
Columbia Univ College of Physicians & Surgeons	Instructor in Clinical Pediatrics	7/82 - present

List all other states where you are or have been licensed: New York #142908

Are you a Diplomate of a Specialty Board? Family Medicine 1983
(name, if applicable)

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

012166 HAND Delivered

Board Use Only:

Registration No.	Status	Fee	Renewal Date
58220	1	$150	07/05/89

MARTHA F KATZ

JUN 1989 RECEIVED

M.R. Pr. Bk. Ch. 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:) KATZ (FIRST:) MARTHA (M.I.:) ELLEN

1. b) Other Name(s), if any, that you were ever licensed under:

2. a) Address (Mailing): Same as above

2. b) Address (Home): Same as above

2. c) Address (Business): MARTHA ELIOT HEALTH CENTER, 33 BICKFORD ST.
JAMAICA PLAIN, MA 02130

2. d) Telephone (Business): (617) 522-5300 Extension 211 2. e) Telephone (Home) *(Optional)*:

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

6. a) Medical School Code *(See Table 1)*: NY001 *If 99999, write* Name:

6. b) Year Graduated: 1979 6. c) Degree: M.D. X D.O. ___

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

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

10 Hospital	100 %	15 Private Office	___%	20 Partnership/Group Practice	___%
25 Clinic	___%	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	60 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 8/19/87
30 Administrative Activities	30 %	40 Medical Teaching	10 %	
50 Medical Research	___%	99 Other	___%	

9. Specialty Code *(See Table 3)*: FP Percent of Practice Time: 0 % Specialty Code: IM Percent of Practice Time: 100 %
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: 921 0 %	Facility Code: ___ ___ ___%	Facility Code: ___ ___ ___%
Facility Code: 139 100%	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: 999 Facility Code: ___ ___ Facility Code: ___ ___ Facility Code: ___ ___ Facility Code: ___ ___

If 999, write Name(s): ST. LUKE'S - ROOSEVELT HOSP, NEW YORK, NY; MONTEFIORE HOSP & MED. CENTER BRONX, NEW YORK

* 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 (#) ___ attached pages--is true.

Signature: Martha Ellen Katz Date: 6/30/89

(See reverse side)

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

Fill in name and number. **Physician Last Name:** KATZ **Registration No.:** 58220 ~~2K0 58 24~~ 90

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

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

13. I am applying to be registered with the following status: ACTIVE X 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: 121 hrs., Category II: 25 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 X LETTER OF CREDIT ___. *If applicable, check one and identify the name.*
Insurer: GEICO 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 <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> 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 <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> 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):*		

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

RECEIVED
JUN 19 2003
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. 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.: 58220 Renewal Date: 07/05/2003

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. MARTHA E KATZ
HARVARD MEDICAL SCHOOL
164 LONGWOOD AVE #310
BOSTON, MA 02115-5701

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

Business Address: _____
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: Columbia Univ. College of Physicians & Surgeons
b) Year Graduated: 1979 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
FP	0	Family Practice
IM	0	Internal Medicine

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

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: 1391 (AP) 50 % Facility Code: 4411✓ (AP) 0 % Facility Code: ___/___ (AP) ___ %
Facility Code: 9211✓ (AP) .5 % Facility Code: 4131✓ (AP) 45 % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: MARTHA ELLEN KATZ, M.D. LICENSE NUMBER: 58220

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

Insurer's name. (Required): Controlled Risk Ins Company of Vermont Inc Policy dates: From: 01/01/03 To: 12/31/08

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) 1 0 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 4 hrs/wk B) outpatient care 40 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care? 80 %

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.

	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: Martha Ellen Katz MD Date: 6/16/03

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 Board of Registration in Medicine Physician Profile

MARTHA E KATZ MD

I. Physician Information

(The information in sections I - V has been provided by the physician.)

License Status:	Active
License Issue Date:	08/19/1987
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Hospital
Business Address:	HARVARD MEDICAL SCHOOL 164 LONGWOOD AVE #310 BOSTON, MA 021155701
Phone:	(617) 971-2100
Translation Services Available:	None Reported
Insurance Plans Accepted:	Blue Cross Blue Shield Numerous Plans Accepted Tufts
Hospital Affiliations:	Children's Hospital Harvard University Health Services Brigham & Women's Hospital Beth Israel Deaconess Medical Center

University Health Service
Harvard Univ
75 MT. Auburn ST
Cambridge, MA 02138
617 495 5711

II. Education & Training

Medical School:	Columbia Univ. College of Physicians & Surgeons
Graduation Date:	1979
Post Graduate Training:	7/1/1979-6/30/1990 - MONTEFIORE HOSPITAL - INTERN:FAMILY MEDICINE 7/1/1980-6/30/1982 - MONTEFIORE HOSPITAL - RESIDENT:FAMILY MEDICINE 2/1/1982-3/31/1982 - MARCH OF DIMES; CHAPEL HILL,NC - FELLOW:MATERNAL/CHILD 9/1/1991-6/30/1992 - CARNEY HOSPITAL, MA - SENIOR FELLOW 6/30/1992-12/31/1992 - BRIGHAM & WOMEN'S HOSPITAL, MA - CLINICAL SCHOLAR:FAMILY PLANNI

III. Specialty

Massachusetts Physician Renewal Application

Physician Name: MARTHA E KATZ **License No.:** 58220

PART A

1) Current Status: Active **Renewal Due Date:** 06/07/2005 **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

HARVARD MEDICAL SCHOOL
164 LONGWOOD AVE #310
BOSTON, MA 02115-5701

☑ *Check here to change this address*

Please make corrections (print)

Mailing Address: Univ. Health Service Harvard Univ
75 MT. Auburn ST
City/Town: Cambridge State: MA
Zip: 02138 Country: USA

RECEIVED
JUN 22 2005
BOARD OF REGISTRATION IN MEDICINE

2b) HOME ADDRESS

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

Phone:

☐ *Check here to change this address*

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

HARVARD MEDICAL SCHOOL
164 LONGWOOD AVE #310
BOSTON, MA 02115-5701

Phone: (617)971-2100 Ext. 211

☒ *Check here to change this address*

Business Address: same
City/Town: State:
Zip: Country:
Business Telephone: (617) 495-5711

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 617 495-8078

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Family Practice	☐	
Internal Medicine	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☒	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: MARTHA E KATZ **License No.:** 58220

(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.)**
a) Massachusetts:	
b) Federal (DEA)	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	NY

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: 37

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		*Approximate* # Hours per Week
		Current	Change	
Beth Israel Deaconess Medical Center	☐	ASSOC		0
Brigham & Women's Hospital	☐	ACTIVE		1
Children's Hospital	☐	ACTIVE		0
Harvard University Health Services	☐	ACTIVE		37
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 4 hrs/wk Change to: 10 hrs/wk

b) outpatient care 40 hrs/wk Change to: 30 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: CRICO Change to: _____

Policy dates: From 01/01/05 To 12/31/05 *(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: MARTHA E KATZ **License No.:** 58220

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: MARTHA E KATZ **License No.: 58220**

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: 6/20/05

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: MARTHA E KATZ **License No.: 58220**

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. 6/23/05

☐ 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.

6/23/05

Signature: _____ Date: 6/20/05

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

Massachusetts Board of Registration in Medicine Physician Profile

lic# 58220

MARTHA E KATZ MD

I. Physician Information

(The information in sections I - V has been provided by the physician.)

License Status:	Active
License Issue Date:	08/19/1987
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Hospital
Business Address:	HARVARD MEDICAL SCHOOL 164 LONGWOOD AVE #310 BOSTON, MA 021155701
Phone:	(617) 971-2100
Translation Services Available:	None Reported yes
Insurance Plans Accepted:	Blue Cross Blue Shield Numerous Plans Accepted Tufts
Hospital Affiliations:	Children's Hospital Harvard University Health Services Brigham & Women's Hospital Beth Israel Deaconess Medical Center

University Health Serlve
Harvard Univ
75 Mt. Auburn ST
Cambridge, MA 02138
617 495 5711

II. Education & Training

Medical School:	Columbia Univ. College of Physicians & Surgeons
Graduation Date:	1979
Post Graduate Training:	7/1/1979-6/30/1990 - MONTEFIORE HOSPITAL - INTERN:FAMILY MEDICINE 7/1/1980-6/30/1982 - MONTEFIORE HOSPITAL - RESIDENT:FAMILY MEDICINE 2/1/1982-3/31/1982 - MARCH OF DIMES; CHAPEL HILL,NC - FELLOW:MATERNAL/CHILD 9/1/1991-6/30/1992 - CARNEY HOSPITAL, MA - SENIOR FELLOW 6/30/1992-12/31/1992 - BRIGHAM & WOMEN'S HOSPITAL, MA - CLINICAL SCHOLAR:FAMILY PLANNI

III. Specialty

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.:** 58220

PART A

1) Current Status: Active **Renewal Due Date:** 06/07/2007 **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.

RECEIVED
JUN 05 2007
Board of Registration in Medicine

2a) MAILING ADDRESS
Univ Health Service Harvard Univ

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS
Univ Health Service Harvard Univ

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
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge, MA 02138

Phone: (617)495-5711

☐ *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: 617-495-8078

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

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Family Practice	☐	
Internal Medicine	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.: 58220**

(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:		
b) Federal (DEA)		**9) States where you were previously licensed**
c) Federal (DEA) XS:		NY

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?**
Beth Israel Deaconess Medical Center			☐
Brigham & Women's Hospital			☐
Children's Hospital Boston			☒
Harvard University Health Services			☐
			☐

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

Average weekly hours involved in: a) inpatient care 10 hrs/wk Change to: _____ hrs/wk

b) outpatient care 30 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: CRICO Change to: _____

Policy dates: From 1/1/07 To 12/31/07

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: Martha E Katz, M.D. **License No.: 58220**

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: Martha E Katz, M.D. **License No.: 58220**

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: 6/1/07

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.

MARTHA ELLEN KATZ, M.D.

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.: 58220**

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: 1942213517

☐ 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:	207Q00000X	family Practice
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): NY Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI 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: 6/1/07

MARTHA ELLEN KATZ, M.D.

Mass.Gov

Massachusetts Board of Registration in Medicine Physician Profile

Martha E. Katz, M.D.

I. Physician Information

(The information in sections I - VI has been provided by the physician.)

License Status:	Active
License Issue Date:	8/19/1987
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Hospital
Business Address:	Univ Health Service Harvard Univ 75 Mt. Auburn Street Cambridge, MA 02138
Phone:	(617) 495-5711
Translation Services Available:	Trans. Service
Insurance Plans Accepted:	Blue Cross Blue Shield Numerous Plans Accepted Tufts
Hospital Affiliations:	Beth Israel Deaconess Medical Center (Associate) Brigham & Women's Hospital (Active) ~~Children's Hospital Boston (Active)~~ Harvard University Health Services (Active)

did not renew

II. Education & Training

Medical School:	Columbia Univ. College of Physicians & Surgeons
Graduation Date:	1979
Post Graduate Training:	MONTEFIORE HOSPITAL - INTERN:FAMILY MEDICINE (7/1/1979-6/30/1990) MONTEFIORE HOSPITAL - RESIDENT:FAMILY MEDICINE (7/1/1980-6/30/1982) MARCH OF DIMES; CHAPEL HILL,NC - FELLOW:MATERNAL/CHILD (2/1/1982-3/31/1982) CARNEY HOSPITAL, MA - SENIOR FELLOW (9/1/1991-6/30/1992) BRIGHAM & WOMEN'S HOSPITAL, MA - CLINICAL SCHOLAR:FAMILY PLANNI (6/30/1992-12/31/1992)

III. Specialty

Area of Specialty: Family Practice
Internal Medicine

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Practice	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

NOTES FROM THE FIELD:THE WOMEN'S HEALTH PROGRAM AT COLUMBIA UNIVERSITY,AM J PUBLIC HEALTH,1987.
VARIATION IN HYSTERECTOMY RATES ACROSS SMALL GEOGR APHIC AREAS OF MASS,AM J OBSTET GYNECOL,1993.
MORTALITY RAGES AMONG 15-44 YEAR OLD WOMEN IN BOST ON:LOOKING BEYOND REPRODUCTIVE STATUS,AM J PUBLIC HEALTH,1995.

VII. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.
When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when

considering malpractice averages.

- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Katz has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Katz has had no criminal convictions in the past ten years.

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Katz has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Katz has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 617-654-9830
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118

Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.:** 58220

PART A

1) Current Status: Active **Renewal Due Date:** 06/07/2007 **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.

RECEIVED
JUN 05 2007
Board of Registration in Medicine

2a) MAILING ADDRESS

Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge, MA 02138

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

RECEIVED
JUN 28 2007
Board of Registration in Medicine

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

Univ Health Service Harvard Univ

Phone:

☐ *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: 617-495-8078

Correct your E-mail and Fax Number below:

_____

_____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Family Practice	☐	
Internal Medicine	☐	
	☐	

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?**
Family Medicine	ABMS	Family Practice	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.: 58220**

(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

NY

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?
Beth Israel Deaconess Medical Center			☐
Brigham & Women's Hospital			☐
Children's Hospital Boston			☒
Harvard University Health Services			☐
			☐

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

Average weekly hours involved in: a) inpatient care 10 hrs/wk Change to: _____ hrs/wk

b) outpatient care 30 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: CRICO Change to: _____

Policy dates: From 1/1/07 To 12/31/07

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.

6/26/07

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.: 58220**

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: Martha E Katz, M.D. **License No.: 58220**

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: 6/1/07 6/20/07

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.

MARTHA ELLEN KATZ, M.D.

Massachusetts Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.: 58220**

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: 1942213517

☐ 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:	207Q00000X	family Practice
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): NY Country of Birth (if outside the US): _____

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI 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: 6/1/07

MARTHA ELLEN KATZ, M.D.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.:** 58220

Current Status: Active **License Expiration Date:** 7/5/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America

Home Address:

Business Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America
(617) 495-5711

3) **Email Address:**

4) **Fax Number:** (617) 495-8078

5) **Specialties**
Family Medicine
Internal Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
New York

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
Beth Israel Deaconess Medical Center	

Brigham & Women's Hospital
Harvard University Health Services

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 10 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	1/1/2009	12/31/2009	Claims made with tail coverage

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

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

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

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

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

18) Other Civil Lawsuits
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: Martha E Katz, M.D. **License No.:** 58220

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, 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:
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 physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

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

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Martha E Katz, M.D. **License No.:** 58220

Current Status: Active **License Expiration Date:** 7/5/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America

Home Address:

Business Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America
(617) 495-5711

3) **Email Address:**

4) **Fax Number:** (617) 495-8078

5) **Specialties**
Family Medicine
Internal Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
New York

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
Beth Israel Deaconess Medical Center	

Brigham & Women's Hospital
Harvard University Health Services

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/01/2011	12/31/2011	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

Physician Name: Martha E Katz, M.D. **License No.:** 58220

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?

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: Martha E Katz, M.D. **License No.:** 58220

Current Status: Active **License Expiration Date:** 7/5/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America

Home Address:

Business Address:
Univ Health Service Harvard Univ
75 Mt. Auburn Street
Cambridge
Massachusetts - 02138
United States of America
(617) 495-5711

3) **Email Address:**

4) **Fax Number:** (617) 495-8078

5) **Specialties**
Family Medicine
Internal Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
New York

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
Beth Israel Deaconess Medical Center	

Brigham & Women's Hospital
Harvard University Health Services

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/01/2012	12/31/2013	Claims made with tail coverage

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

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

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

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

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

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

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

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

Physician Name: Martha E Katz, M.D. **License No.:** 58220

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?

Physician Name: Martha E Katz, M.D. **License No.:** 58220

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.

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