REDACTED COPY

**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**

Registration No.: 160382 Renewal Date: 08/26/2000 1. Current Status: Active

If you want to change your current status, please indicate below: (Check one). I DO NOT WANT TO CHANGE MY STATUS

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

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

RECEIVED BOARD OF REGISTRATION IN MEDICINE JAN 29 2000

3. A) Mailing/~~Business~~ Address: Matthias G Muenzer BUSINESS ADRESS

B) Home Address:

Home Phone:
Business Phone: (978) 465-9133

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

5. A) Name of Medical School: Ludwig-Maximilians University, MUNICH, GERMANY
B) Year Graduated: 1981 C) Degree: M.D.

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

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

**Please make corrections** (type or print)

Other Name(s): SEACOAST OB/GYN
~~Mailing~~ Address: 260 MERRIMAC ST
City/Town: NEWBURYPORT State: MA
Zip: 01950 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 |
|---|---|
| OBG | 40+ |
| | |
| | |

If OS, Print Specialty:

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

Code: Code:

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

Federal (DEA):
Mass:

9. A) Other states where you are now licensed to practice NONE
Abbr:
B) States where you previously were licensed to practice ON FILE
Abbr:

Abbr:
Abbr:

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

**PRINT NAME AND NUMBER:** Last Name: MUENZER Registration Number: 160382

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: 6 ✓ / ___ (AP) 15 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %

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

If 999, print name(s): ___

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

Name of Insurer: PIAM, WALTHAM, MA Alternatively, indicate as follows:

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

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) 20

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

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

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

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

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

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

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

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ 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: ___ Date: 6/21/00

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

Application #: 160382
Date of Issue: _____

**Commonwealth of Massachusetts - Board of Registration in Medicine**
**10 West Street, 3rd Floor**
**Boston, MA 02111 - (617) 727-3086**

# FULL LICENSE APPLICATION

**Application Fee:** Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

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

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

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

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____

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

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

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

Place of Birth: GROSSEN-BUSECK (City) HESSEN (State/Province/Territory) GERMANY (WEST) (Country if not USA)

Home Address: _____ (Number and Street)

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

Business Address: 330 BROOKLINE AVE
Number and Street

BOSTON (City) MA (State/Province/Territory) 02215 (Zip (or postal) Code)

Business Telephone: (617) 667-2295 ext. _____ Home Telephone: _____

Preferred Mailing Address: ☐ Business Address ☑ Home Address



DATE: 6-22
INITIAL: LLB
FEE: $350.00 Check 1896

APPLICANT'S NAME: MUENZER, MATTHIAS MD

**Pre-medical School**

Facility: DOES NOT APPLY IN GERMANY Degree: ____ From __/__/__ To __/__/__
Street: ____ City: ____ State: ____

Facility: ____ Degree: ____ From __/__/__ To __/__/__
Street: ____ City: ____ State: ____

**Medical School**

Facility: LUDWIG-MAXIMILIAN-UNIVERSITAET SCHOOL OF MEDICINE Degree: MD From 5/75 To 10/81
Street: BAVARIARING 19 City: MUENCHEN 80336 State: GERMANY

Facility: ____ Degree: ____ From __/__/__ To __/__/__
Street: ____ City: ____ State: ____

Date of medical school graduation: 10/81

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

**Postgraduate Education:**

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

Facility: MED. DEPT, WILHELMSHAVEN NAVY BASE Position: PHYSICIAN GEN. PRACTITIONER From 8/82 To 10/83
Street: HEPPENSER GRODEN City: 26384 WILHELMSHAVEN State: GERMANY

Facility: AUGSBURG CENTRAL HOSPITAL, ANESTHESIA Position: INTENSIVE CARE RESIDENT PGY1 From 1/1/84 To 3/1/85
Street: STENGLINSTR City: 8900 AUGSBURG State: GERMANY

Facility: ERLANGEN-NUERNBERG UNIVERSITY INSTITUTE OF PATHOLOGY Position: RESIDENT PGY1 From 4/1/85 To 7/31/86
Street: KRANKENHAUSSTR. 8-10 City: 8520 ERLANGEN State: GERMANY

Facility: NUERNBERG GENERAL HOSPITAL DEPT OF OB/GYN (FRAUENKLINIK) Position: RESIDENT PGY1 From 8/1/86 To 12/1/86
Street: FLURSTR. 7 City: 8500 NUERNBERG 90 State: GERMANY

Facility: BAMBERG HOSPITAL AND MED. CTR DEPT. OF SURGERY Position: RESIDENT PGY 1+2 From 1/1/87 To 4/1/89
Street: BUGERSTRASSE 60 City: 8600 BAMBERG State: GERMANY

ATTACHED LIST

APPLICANT'S NAME: MUENZER, MATTHIAS MD

**Hospital Affiliations and Employment**

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

PLEASE SEE ATTACHED LIST !

| | | | From | To |
|---|---|---|---|---|
| DEPT OF OB/GYN | PGY 1-5 | | | |
| Facility: BARMBEK GENERAL HOSPITAL | Position: RESIDENT | | 5/1/89 | 10/1/94 |
| Street: RUEBEN KAMP 148 | City: 22307 HAMBURG - BARMBEK | State: GERMANY | | |
| Facility: PRACTICE LEIDENBERGER AND PARTNER | Position: ATTENDING | | 11/1/94 | 3/22/95 |
| Street: LORNSEN STR. 4 | City: 22709 HAMBURG | State: GERMANY | | |
| DEPT OF OB/GYN | PGY 1+2 | | | |
| Facility: NASSAU COUNTY MEDICAL CTR | Position: RESIDENT | | 5/22/95 | 6/30/97 |
| Street: 2201 HEMPSTEAD TPKE | City: EAST MEADOW | State: NY 11554 | | |
| DEPT OF OB/GYN | PGY 3+4 | | | |
| Facility: BETH ISRAEL DEACONESS MED CTR | Position: RESIDENT | | 6/29/97 | 6/18/99 |
| Street: ~~330 BROOKLINE AVE~~ | City: ~~BOSTON~~ | State: ~~MA~~ 02215 | | |

GERMANY

1. List other states (abbreviations) where you are currently or have ever been licensed: ___ ___ ___

2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☑ No

3. List Board Certification(s): ___

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

5. Reason for requesting a Massachusetts medical license: ___

WANT TO WORK AS GYNECOLOGIST IN MASS.

6. Name of Facility: SOUTH SHORE HOSPITAL

7. Address: 55 FOGG RD City: SOUTH WEYMOUTH

8. Anticipated starting date in Massachusetts: 7/1/99 MA 02190

**Affidavit of Applicant**

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

M. Muenzer
Signature of Applicant

5/7/99
Date

**Addendum to Page 2 of**
**Full License Application**

# Postgraduate Education

**Matthias G. Muenzer, MD, DOB , SSN**

**Resident,**
PGY 4 from 6/21/98 – 6/18/99
PGY 3 from 6/29/97 – 6/20/98
Department of Obstetrics and Gynecology,
**Beth Israel Deaconess Medical Center**
330 Brookline Ave
Boston, MA 02215
Program Director: Henry Klapholz, MD
Tel: (617) 667-2285

**Resident**
PGY 1 and PGY 3
5 / 22 / 95 through 6 / 30 / 97
Department of Obstetrics and Gynecology,
**Nassau County Medical Center,**
2201 Hempstead Turnpike
East Meadow, NY 11554. USA
Chairman: Peter Hong, MD
Program Director: Elsie Santana-Fox, MD
Tel: (516) 572-6255

**Associate Attending**
11 / 1 / 94 to 3 / 22 / 95.
**Practice Leidenberger, Weise and Partners,**
Specialists in Endocrinology and Infertility,
Lornsenstr. 4
22709 Hamburg, Germany,
Director: Prof. Freimut Leidenberger
Tel: 011-49-40-3802110

**Resident,** PGY 1 – PGY 5
May 1989 to graduation in October 1994
Department of Obstetrics and Gynecology
**Barmbek General Hospital and Medical Center**
Ruebenkamp 148
22307 Hamburg-Barmbek, Germany
Program Director: Prof. Dr. Constantin Martin
Tel: 01149-40-6385-3511
Fax: 01149-40-6385-2171

**Resident**
PGY 1 and 2
January 87 - April 1989
Abdominal and Vascular Surgery (1988 and 1-4/89)
Trauma Surgery (1987)
**Bamberg Hospital and Medical Center**
Buger Str. 60
8600 Bamberg, Germany
Director General Surgery: Prof. Dr. Joachim Eisenbach
Tel: 011-49-951-5030
Director Trauma Surgery: Prof. Dr. Hans Joachim Wiendl
Tel: 011-49-951-5030

**Resident,** PGY 1
August 1986 - December 1986
Department of Obstetrics and Gynecology (Frauenklinik)
**Nuernberg General Hospital and Medical Center (Klinikum Nuernberg)**
Flurstr. 7
8500 Nuernberg 90, Germany
Chairman and Program Director: Prof. Dr. Guenther Stark
Tel: 011-49-911-398-2222

**Resident,** PGY 1 and 2
April 1985 - July 1986
**Institute of Pathology**
**Erlangen-Nuernberg University Hospital and Medical Center**
Krankenhausstr. 8-10
8520 Erlangen, Germany
Chairman and Program Director: Prof. Dr. Volker Becker
Tel: 011-49-9131-85-2286

**Resident**, PGY 1
January 1984 - March 1985
Anesthesiology and Surgical Intensive Care
**Augsburg Central Hospital and Medical Center (Zentralklinikum Augsburg)**
Stenglinstrasse
8900 Augsburg, Germany
Chairman and Program Director: Prof. Dr. Joachim Eckart
Tel: 011-49-821-4001

Military Service as **General Practitioner** at the Wilhelmshaven Navy Base,
August 1982 - October 1983
**Medical Department**
**Marinestuetzpunkt Heppenser Groden**
26384 Wilhelmshaven, Germany
Director of the Facility: Dr. Pietsch, Flotillenarzt, Chef der Marinesanitaetsstaffel
Tel: 011-49-4421-5201

May 1975 - December 1981
Medical School of
Ludwig-Maximilian-University (LMU) in Munich,
Studiendekanat der LMU
Bavariaring 19
80336 Muenchen, Germany,
Studiendekan (dean of students): Prof. Dr. H. Gastpar, Associate Dean
011-49-89-5160-7553

**Addendum to Page 3 of**
**Full License Application**

# Hospital Affiliations and Employment

**Matthias G. Muenzer, MD, DOB , SSN**

**Resident,**
PGY 4 from 6/21/98 – 6/18/99
PGY 3 from 6/29/97 – 6/20/98
Department of Obstetrics and Gynecology,
**Beth Israel Deaconess Medical Center**
330 Brookline Ave
Boston, MA 02215
Program Director: Henry Klapholz, MD
Tel: (617) 667-2285

**Resident**
PGY 1 and PGY 3
5 / 22 / 95 through 6 / 30 / 97
Department of Obstetrics and Gynecology,
**Nassau County Medical Center,**
2201 Hempstead Turnpike
East Meadow, NY 11554. USA
Chairman: Peter Hong, MD
Program Director: Elsie Santana-Fox, MD
Tel: (516) 572-6255

**Associate Attending**
11 / 1 / 94 to 3 / 22 / 95.
**Practice Leidenberger, Weise and Partners,**
Specialists in Endocrinology and Infertility,
Lornsenstr. 4
22709 Hamburg, Germany,
Director: Prof. Freimut Leidenberger
Tel: 011-49-40-3802110

**Addendum to Page 2 of**
**Full License Application**

# Postgraduate Education

**Of Matthias G. Muenzer, MD, dob** **SSN**

Resident,
PGY 3 from 6/29/97 – 6/20/98
PGY 4 from 6/21/98 – 6/18/99
Department of Obstetrics and Gynecology,
Beth Israel Deaconess Medical Center
330 Brookline Ave
Boston, MA 02215

Resident
PGY 1 and PGY 3
5 / 22 / 95 through 6 / 30 / 97
Department of Obstetrics and Gynecology,
Nassau County Medical Center,
2201 Hempstead Turnpike
East Meadow, NY 11554. USA

Associate Attending
11 / 1 / 94 to 3 / 22 / 95.
Practice Leidenberger, Weise and Partners,
Specialists in Endocrinology and Infertility,
Lornsenstr. 4
22709 Hamburg, Germany,

Resident, PGY 1 – PGY 5
May 1989 to graduation in October 1994
Department of Obstetrics and Gynecology
Barmbek General Hospital and Medical Center
Ruebenkamp 148
22307 Hamburg, Germany

Resident
PGY 1 and 2
January 87 - April 1989
Abdominal and Vascular Surgery (1988 and 1-4/89)
Trauma Surgery (1987)
Bamberg Hospital and Medical Center
Buger Str. 60
8600 Bamberg, Germany

Please see over

Resident, PGY 1
August 1986 - December 1986
Department of Obstetrics and Gynecology (Frauenklinik)
Nuernberg General Hospital and Medical Center (Klinikum Nuernberg)
Flurstr. 7
8500 Nuernberg 90, Germany

Resident, PGY 1 and 2
April 1985 - July 1986
Institute of Pathology
Erlangen-Nuernberg University Hospital and Medical Center
Krankenhausstr. 8-10
8520 Erlangen, Germany

Resident, PGY 1
January 1984 - March 1985
Anesthesiology and Surgical Intensive Care
Augsburg Central Hospital and Medical Center (Zentralklinikum Augsburg)
Stenglinstrasse
8900 Augsburg, Germany

Military Service as General Practitioner at the Wilhelmshaven Navy Base,
August 1982 - October 1983
Marinestuetzpunkt Heppenser Groden
Wilhelmshaven, Germany

May 1975 - December 1981
Medical School of
Ludwig-Maximilian-University (LMU) in Munich,
Studiendekanat der LMU
Bavariaring 19
80336 Muenchen, Germany,

**Addendum to Page 3 of**
**Full License Application**

# Hospital Affiliations and Employment

**Matthias G. Muenzer, *MD, DOB*** **, SSN**

**Resident,**
PGY 4 from 6/21/98 – 6/18/99
PGY 3 from 6/29/97 – 6/20/98
Department of Obstetrics and Gynecology,
**Beth Israel Deaconess Medical Center**
330 Brookline Ave
Boston, MA 02215
Program Director: Henry Klapholz, MD
Tel: (617) 667-2285

**Resident**
PGY 1 and PGY 3
5 / 22 / 95 through 6 / 30 / 97
Department of Obstetrics and Gynecology,
**Nassau County Medical Center,**
2201 Hempstead Turnpike
East Meadow, NY 11554. USA
Chairman: Peter Hong, MD
Program Director: Elsie Santana-Fox, MD
Tel: (516) 572-6255

**Associate Attending**
11 / 1 / 94 to 3 / 22 / 95.
**Practice Leidenberger, Weise and Partners,**
Specialists in Endocrinology and Infertility,
Lornsenstr. 4
22709 Hamburg, Germany,
Director: Prof. Freimut Leidenberger
Tel: 011-49-40-3802110

**Resident**, PGY 1 – PGY 5
May 1989 to graduation in October 1994
Department of Obstetrics and Gynecology
**Barmbek General Hospital and Medical Center**
Ruebenkamp 148
22307 Hamburg-Barmbek, Germany
Program Director: Prof. Dr. Constantin Martin
Tel: 01149-40-6385-3511
Fax: 01149-40-6385-2171

**Resident**
PGY 1 and 2
January 87 - April 1989
Abdominal and Vascular Surgery (1988 and 1-4/89)
Trauma Surgery (1987)
**Bamberg Hospital and Medical Center**
Buger Str. 60
8600 Bamberg, Germany
Director General Surgery: Prof. Dr. Joachim Eisenbach
Tel: 011-49-951-5030
Director Trauma Surgery: Prof. Dr. Hans Joachim Wiendl
Tel: 011-49-951-5030

**Resident**, PGY 1
August 1986 - December 1986
Department of Obstetrics and Gynecology (Frauenklinik)
**Nuernberg General Hospital and Medical Center (Klinikum Nuernberg)**
Flurstr. 7
8500 Nuernberg 90, Germany
Chairman and Program Director: Prof. Dr. Guenther Stark
Tel: 011-49-911-398-2222

**Resident**, PGY 1 and 2
April 1985 - July 1986
**Institute of Pathology**
**Erlangen-Nuernberg University Hospital and Medical Center**
Krankenhausstr. 8-10
8520 Erlangen, Germany
Chairman and Program Director: Prof. Dr. Volker Becker
Tel: 011-49-9131-85-2286

**Resident**, PGY 1
January 1984 - March 1985
Anesthesiology and Surgical Intensive Care
**Augsburg Central Hospital and Medical Center (Zentralklinikum Augsburg)**
Stenglinstrasse
8900 Augsburg, Germany
Chairman and Program Director: Prof. Dr. Joachim Eckart
Tel: 011-49-821-4001

**Military Service** as **General Practitioner** at the Wilhelmshaven Navy Base,
August 1982 - October 1983
**Medical Department**
**Marinestuetzpunkt Heppenser Groden**
26384 Wilhelmshaven, Germany
Director of the Facility: Dr. Pietsch, Flotillenarzt, Chef der Marinesanitaetsstaffel
Tel: 011-49-4421-5201

May 1975 - December 1981
Medical School of
Ludwig-Maximilian-University (LMU) in Munich,
Studiendekanat der LMU
Bavariaring 19
80336 Muenchen, Germany,
Studiendekan (dean of students): Prof. Dr. H. Gastpar, Associate Dean
011-49-89-5160-7553

**CURRICULUM VITAE** , May 10, 1999

**Matthias G. Muenzer, MD**

## TRAINING IN OBSTETRICS AND GYNECOLOGY

Chief Resident, 7/98 - 6/99 and resident 7/97-6/98
Beth Israel Deaconess Medical Center, Boston
Clinical Instructor, Harvard Medical School
(special training in advanced operative laparoscopy including laparoscopic supracervical hysterectomy, myomectomy and Burch procedure)

Resident, 5/95 - 6/97
Nassau County Medical Center, East Meadow, NY 11554
Affiliated with SUNY at Stony Brook
(high volume general Ob/Gyn)

Attending at office Leidenberger, Weise and Partners, 11/94 - 3/95
Reproductive Endocrinology and Infertility, Hamburg, Germany,
(In vitro fertilization)

Resident in Obstetrics and Gynecology, 5/89 – graduation in 10/94
Barmbek General Hospital and Medical Center, Hamburg, Germany
(Included management and surgery of breast diseases as well as a one-year fellowship in Ob/Gyn-sonography at a level III referral center)

## SPECIAL TRAINING AND INTERESTS

**Laparoscopy and minimally invasive surgery**, based on rotations with Dr. Robert Hunt, Harvard Medical School, Chief Editor of the Journal of the American Association of Gynecological Laparoscopists and with Dr. Anthony DiSciullo, Director of Gynecology, Mount Auburn Hospital in Cambridge.

- Training included extensive adhesiolysis, resection of severe endometriosis, laparoscopic hysterectomy, myomectomy and Burch procedure. I am familiar with a large variety of ports, graspers, electrosurgical instruments and staplers, with laser, harmonic scalpel, intra- and extracorporeal knot tying and with the use of the motorized morcellator.

- Hysteroscopic procedures included resection of fibroids with loop or Versapoint, endometrial ablation using loop, rollerball and balloon.
- Attendance of the
  International Congress of Gynecological Endoscopy 11/98 in Atlanta, of the Advanced Gynecologic Laparoscopy Course of Ethicon in Cincinnati 12/98 and of the World Congress on Alternatives to Hysterectomy in Miami 2/99
- Member of the American Association of Gynecologic Laparoscopists

**Sonography**, based on a one-year fellowship level training at a level III ultrasound referral center at Barmbek General Hospital in Hamburg, Germany. This included fetal echocardiography, the use of Doppler, Color-Doppler and ultrasound guided punctures.

## PREVIOUS PROFESSIONAL EXPERIENCE

Resident, Abdominal Surgery and Traumatology, 1/87 – 4/89
Bamberg Hospital and Medical Center, Germany

Resident, Obstetrics and Gynecology, 8/86-12/86
Nuernberg General Hospital and Medical Center, Germany

Resident, Institute of Pathology, 4/85-7/86
Erlangen-Nuernberg University Hospital and Medical Center, Germany

Resident, Anesthesiology and Surgical Intensive Care, 1/84-3/85
Augsburg Central Hospital and Medical Center, Germany

Military Service at the Wilhelmshaven Navy Base, Germany, 8/82 – 10/83
(mandatory military service, primary care in an ambulatory center of a large navy base)

## MEDICAL SCHOOL

Medical School of Ludwig-Maximilian-University in Munich, Bavaria, Germany, 5/75 - 12/81

## RESEARCH AND PUBLICATIONS

| | |
|---|---|
| Publication: | Muenzer M, "Alkaptonurie und Ochronose" Medizinische Klinik 82 (1987) 715-718 |
| Research: | "Xanthinoxidase activity in the liver and intestine of the rat under allopurinol and oxipurinol" at the Department of Internal Medicine of Munich University Medical Center, '82-'84 |
| Poster: | "Ochronosis of the Eye" at Erlangen-Nuernberg University, '86 |
| Lectures: | "Alcaptonuria and Ochronosis" at Erlangen-Nuernberg University, '86<br>"Alcaptonuria and Ochronosis" for pathologists at Munich University, '86<br>"Endometriosis" in '95 at Nassau County Medical Center<br>"Obstetrical Sonography" in '96 at Nassau County Medical Center<br>Grand Rounds at BIDMC on "Gynecologic Sonography" in '97 and on "Adhesions, Pathogenesis and Prevention" in '99 |

## MISCELLANEOUS

- Board certified in Ob/Gyn in Germany 4/95
- Member of the committee for graduate medical education at BIDMC 7/98-6/99
- Member of the Committee for Quality Assurance in Gynecological Surgery, Hamburg 2/93 - 10/94
- Translation of large section of the Mosby 1993 Yearbook of Ob/Gyn into German
- **I grew up in Madrid, Spain and speak and write Spanish fluently**

## PERSONAL DATA

Born: near Frankfurt / Main, West Germany in 1954
Married to:
Children: one son, , born
German citizen, **unrestricted green card**

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

# MALPRACTICE HISTORY

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

**Waiver for Release of Information**

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

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

Liability Carrier: CRICO / RISK MANAGEMENT FOUNDATION
City: CAMBRIDGE State: MA 02142
Policy Number: CRC 10024 BIDMC
(101 MAIN ST.)

Liability Carrier: NASSAU COUNTY
City: EAST MEADOW State: NY 11554
Policy Number: SEE ENCLOSED LETTER

Liability Carrier: VEREINTE VERSICHERUNGS AG
City: HANNOVER State: GERMANY 30659
Policy Number: 60-70-51-0901-191 H8
(OFFICE LEIDENBERGER IN HAMBURG)

Liability Carrier: NO CARRIER AT BARMBEK HOSPITAL, HAMBURG !
City: State:
Policy Number:

Please forward the information to the Board of Registration in Medicine at the address above.

Signed: M. Mwenzer 6/7/99
Date

Print Name: MATTHIAS MWENZER MD

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

# STATE LICENSE VERIFICATION

***Applicant's Instructions:*** Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were licensed in the past.

***Applicant's Waiver for Release of Information:***

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registation in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: Matthias G. Muenzer Date: 5/7/99

Print or type name: MATTHIAS G. MUENZER MD

License number: PERMIT# P98104 Status of license: ☐ Active ☒ Inactive ☐ Other (COPY ENCLOSED)

***TO BE COMPLETED BY STATE BOARD***

1. Name of medical school of graduation: _____
2. Date of graduation: ___/___/___ License number: _____ Date of issue: ___/___/___
3. Basis for licensure: _____
   Name(s) of medical licensing examinations(s).
4. Expiration date of license: ___/___/___
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

| | YES | NO |
|---|---|---|
| 7. Has the licensee ever been on probation? | ☐ | ☐ |
| 8. Has the licensee ever been requested to appear before the board? | ☐ | ☐ |

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

*BOARD SEAL*

Signed: _____

Print Name: _____

Title: _____

State Board: _____ Date: ___/___/___

***PLEASE RETURN DIRECTLY TO THE MASSACHUSETTS BOARD OF REGISTRATION***

Application #: 97-6162-99
Date Approved: 3/24/98

BOARD OF REGISTRATION IN MEDICINE
MAR 3 1998

**Commonwealth of Massachusetts Board of Registration in Medicine**
**Ten West Street, Third Floor, Boston, Massachusetts 02111**

# RENEWAL APPLICATION - LIMITED LICENSE

**IMPORTANT:** Please read the accompanying instructions before completing this form, and print legibly or type your answers.

**SECTION A:** Sections A and C on page 2 are to be completed by applicant.

1. Name: (Last) MUENZER (First) MATTHIAS (MI) G
2. Mailing Address: _____ Telephone Number: _____
   City, State and Zip: _____
3. Name of Training Hospital: Beth Israel Deaconess Med Ctr
4. Current Limited License Number: 97-6162-99
5. Other states (abbreviations) where you are now fully licensed to practice medicine: None

**TO BE COMPLETED BY PROGRAM DIRECTOR**

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Henry Klapholz, MD Date: 3/17/98

Signature of Program Director: _____ Telephone: 667-2285

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that Matthias Muenzer, MD (Name of Applicant) has been appointed to the position of: ☐ Intern ☑ Resident ☐ Fellow

Program Name: OB/GYN Facility: Beth Israel Deaconess Med Ctr

Beginning Date: 7/1/97 Anticipated Completion Date of Training: 6/30/99

Is the program accredited by the ACGME: ☑ Yes ☐ No
If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Henry Klapholz, MD (Print Name) Program Director (Title) Telephone: 667-2285

Designated Official's Signature: _____ Date: 3/17/98

APR 13 19

DATE: 3/24/98
INITIAL: RAK
FEE: $50.00 Check

NAME: _____

**SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.**

**SINCE YOUR LAST RENEWAL**

| | | YES | NO |
|---|---|---|---|
| 16. | Have you been granted a leave of absence or withdrawn from a post-graduate training program ? | | |
| 17. | Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating or improper conduct during an examination? | | |
| 18. | Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure? | | |
| 19. | Have you voluntarily surrendered a license to practice medicine or any healing art? | | |
| 20. | Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (national, international, state or local)? | | |
| 21. | Has any disciplinary action (see definition) been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 22. | Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | | |
| 23. | Have you, for any reason, withdrawn an application for hospital privileges or appointment? | | |
| 24. | Have you voluntarily relinquished medical staff membership? | | |
| 25. | Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | | |
| 26. | Have you been charged with any criminal offense, other than a minor traffic offense? | | |
| 27. | Has your privilege to possess, dispense or prescribe controlled substances been restricted, revoked, denied or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency regarding such privileges? | | |
| 28. | Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? | | |
| 29. | Has any lawsuit, other than a medical malpractice suit, which is related to your competency to to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | | |

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

LIMITED
FORM E-IMG

**VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION**

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

Please complete this form in full and return it **DIRECTLY TO THE ADDRESS ABOVE.** This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT MATTHIAS G. MUENZER CREDITAELY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

LUDWIG-MAXIMILIANS-UNIVERSITAET MUENCHEN
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: LUDWIG-MAXIMILIANS-UNIVERSITAET
NAME OF MEDICAL SCHOOL

MUENCHEN, BAVARIA GERMANY
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT MATTHIAS GOTTFRIED MUENZER
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR _____ ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: LUDWIG-MAXIMILIANS-UNIVERSITAET MUENCHEN
NAME OF MEDICAL SCHOOL

FORM E-IMG CONTINUED ON BACK OF THIS PAGE

LIMITED

FORM E-IMG CONTINUED

TO MEDICAL SCHOOL: PLEASE COMPLETE THE ENCLOSED FORMS IN FULL AND ATTACH A COMPLETE OFFICIAL COPY OF APPLICANT'S TRANSCRIPTS. FORMS AND TRANSCRIPTS MUST BE RETURNED DIRECTLY TO THE BOARD OF REGISTRATION IN MEDICINE, TEN WEST STREET, BOSTON, MASSACHUSETTS 02111

Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

APPLICANT NAME: MATTHIAS GOTTFRIED MUENZER

| | MONTH | DAY | YEAR | | MONTH | DAY | YEAR |
|---|---|---|---|---|---|---|---|
| FROM: | 5 | 1 | 75 | TO: | 12 | 31 | 81 |
| FROM: | | | | TO: | | | |
| FROM: | | | | TO: | | | |
| FROM: | | | | TO: | | | |
| FROM: | | | | TO: | | | |
| FROM: | | | | TO: | | | |
| FROM: | | | | TO: | | | |

AND HAS RECEIVED/WILL RECEIVE A DEGREEE OF APPROBATION ALS ARZT

ON 12/30 19 81.

U. Bruder
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

B. Bruder
NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE: May 21, 1997

TRANSCRIPTS ENCLOSED X Yes ___ No If no, please attach an explanation.

MAY 2 1997

**Commonwealth of Massachusetts**
**Board of Registration in Medicine**
**10 West Street, Boston, Massachusetts 02111**

# INITIAL LIMITED LICENSE APPLICATION

**IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.**

97-6162-99

**CHECK ONE:**

- ☐ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
- ☒ Graduate of an International Medical School (IMG)
- ☐ Graduate of an International Medical School applying under the Special Refugee Physician Program

**NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS**

**SECTION A: Sworn Statement to be Completed by Applicant**

1-A. Name: (Last) MUENZER (First) MATTHIAS (MI) G.

1-B. Other Name(s)

| | YES | NO |
|---|---|---|
| 1) Have you ever been known under a different name or combination of names? | | |
| 2) Have you ever been licensed under a different name? | | |
| 3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name? | | |

If yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number: _____

3. Date of Birth (Mo/Da/Yr): _____ Place of Birth: BUSECK / GERMANY

4. Sex: Male X Female _____ 5. Social Security Number: _____

6. Name and address of Massachusetts Training Hospital: BETH ISRAEL DEACONESS MED. CTR, EAST CAMPUS, 330 BROOKLINE AVE, BOSTON, MA 02215 USA

MAY 2 9 1997
SG SO

**NAME:** MATTHIAS G. MUENZER, M.D.

7. Name of premedical school(s) DOES NOT APPLY TO GERMAN

Location: MEDICAL SCHOOL TRAINING
(City, State, Country)

8. Name of medical school(s) LUDWIG-MAXIMILIANS-UNIVERSITAET

Location: MUENCHEN, BAVARIA, GERMANY
(City, State, Country)

Year of Graduation 81 Degree Received: M. D. ☒ D. O. ☐ Other (specify)_____

9. Have you had previous post-graduate training? Yes ☒ No ☐ U.S. ☒ International ☒

Name of Institution: SEE ATTACHED CV

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you are currently licensed to practice medicine:

_____ _____ _____ _____ _____

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):

_____ _____ _____ _____ _____

12. Medical School Training:

| | YES | NO |
|---|---|---|
| a) If you are a USMG, have you taken more than 4 years to complete medical school? | ☐ | ☐ |
| b) If you are an IMG, have you taken more than 6 years to complete medical school? | ☒ | ☐ |

If **yes**, you must provide additional information. (See instructions.)

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts? ☒ ☐
If **yes**, you must provide additional information. (See instructions.)

NAME: MATTHIAS G. MWENZER

| | YES | NO |
|---|---|---|
| 14. Have you ever been enrolled in a residency training program(s) that you did not complete? **If yes, a letter from your program director is required.** (See instructions.) | | |

Explanation attached? X Program Director's Certification requested? _____

**SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.**

| | YES | NO |
|---|---|---|
| 15. Since your matriculation in college, have you been subject to any disciplinary action (see definition) at any academic institution? | | |
| 16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program? | | |
| 17. Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination? | | |
| 18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure? | | |
| 19. Have you ever voluntarily surrendered a license to practice medicine or any healing art? | | |
| 20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |

NAME: MATTHIAS G. MUENZER

| | | YES | NO |
|---|---|---|---|
| 21. | Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 22. | Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | | |
| 23. | Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? | | |
| 24. | Have you ever voluntarily relinquished medical staff membership? | | |
| 25. | Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | | |
| 26. | Have you ever been charged with any criminal offense, other than a minor traffic offense? | | |
| 27. | Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | | |
| 28. | In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | | |
| 29. | In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | | |

NAME: MATTHIAS G. MUENZER, MD

**SECTION C: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that Matthias G. Muenzer MD has been appointed
(Name of Applicant)

to the position of ☐ Intern ☒ Resident ☐ Fellow

in the Beth Israel Deaconess Medical Center OBS-GYN
(Name of Program)

at Beth Israel Deaconess Medical Center
(Name of Hospital)

beginning 6/17/97 (date) to anticipated completion of training: 6/18/98 (date).

| | YES | NO |
|---|---|---|
| Is the program accredited by the ACGME? | ☒ | ☐ |
| If **no**, is there an ACGME-approved training program in the applicant's specialty? | ☐ | ☐ |

Designated Official's Signature: [signature]

Type or Print Name and Title: Henry Klapholz MD

Date: 5/16/97 Telephone Number: 617-667-2285

# Supplement Form

Name: MATTHIAS G. MUENZER, MD Date: 5/7/99

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

| | YES | NO | |
|---|---|---|---|
| 1. | | | Since your matriculation in college, have you been subject to any disciplinary action (see definition) at an academic institution? |
| 2. | | | Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program? |
| 3. | | | Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____ |
| 4. | | | Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination? |
| 5. | | | Have you ever failed any of the following examinations: FLEX examination, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body? |
| 6-A. | | | Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or withdrawn an application for medical licensure? |
| 6-B. | | | Have you ever voluntarily surrendered a license to practice medicine or any healing art? |
| 7. | | | Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards? |
| 8-A. | | | Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? |
| 8-B. | | | Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? |

Continued on page 2

| | YES | NO | |
|---|---|---|---|
| 9-A. | | | Have you ever voluntarily relinquished any medical staff membership? |
| 9-B. | | | Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, denied, not renewed or subject to probationary conditions, or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? |
| 9-C. | | | Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? |
| 9-D. | | | Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? |
| 10. | | | Have you ever been charged with any criminal offense, other than a minor traffic offense? |
| 11. | | | Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by this state or any other jurisdiction including a federal agency regarding such privileges? |
| 12. | | | Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? |
| 13. | | | Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or other third party programs? |
| 14. | | | Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan? |
| 15-A. | | | In the past ten (10) years, has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? |
| 15-B. | | | In the past ten years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? |

Continued on page 3

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



# MEDICAL EDUCATION VERIFICATION

**APPLICANT INSTRUCTIONS**: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

## Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution to the ***Massachusetts Board of Registration in Medicine.***

Applicant's Signature: MATTHIAS G. MUENZER Date of Birth: _____

Print or Type Name: MATTHIAS G. MUENZER Social Security No: _

Name of Medical School: LUDWIG - MAXIMILIAN - UNIVERSITAET MUENCHEN - STUDIENDEKANAT

Address: BAVARIARING 19 City: MUENCHEN State or Province: GERMANY 80336

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

**Please complete this form and forward it, together with a copy of the applicant's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) directly to the Board of Registration in Medicine.**

**APPLICANT'S EDUCATIONAL HISTORY**

If name of institution was different from the above named institution when applicant attended, please enter name below:

_____

**Premedical Education:** Does your school have a premedical school education requirement? ☐ Yes ☑ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Undergraduate School Address: _____

Continued on back

**MEDICAL EDUCATION VERIFICATION**

**Enrollment and Participation:** Our records indicate that

MUENZER, MATTHIAS G.

(type/print applicant's name: *last, first, middle, suffix*)

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

| **ATTENDANCE DATES:** | **FROM** | **TO** | **FROM** | **TO** |
|---|---|---|---|---|
| | MAY / / 1975 | OCTOBER 1981 | / / | / / |
| | / / | / / | / / | / / |
| | / / | / / | / / | / / |

The applicant attended 33 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

*check one* ☑ was awarded a degree in MEDICINE on (month/day/year) 12 / 30 / 1981
(APPROBATION ALS ARZT)

☐ was NOT awarded degree. Please explain reason(s)_____

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

| | **YES** | **NO** |
|---|---|---|
| 1. Did the applicant take any leaves of absence or breaks from his/her medical education? | | |
| 2. Was the applicant ever placed on probation? | | |
| 3. Was the applicant ever disciplined or under investigation? | | |
| 4. Were any negative reports ever filed by instructors regarding the applicant? | | |

COMMENTS:_____

Studiendekanat für Medizin
~~der Ludwig-Maximilians-Universität München~~
Bavariaring 19
80336 München, Tel. 51 60 89 03

**AFFIX INSTITUTIONAL SEAL HERE**

**(if the institution does not have a seal, this form must be notarized)**

**INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.**

Signature: B. Bruder

Print Name: B. Bruder

Title: RegioAres

Date: 06/28/99 Telephone: (089) 5160-8903

POSTGRADUATE VERIFICATION

RECEIVED
MAY 19 1999
BOARD OF REGISTRATION IN MEDICINE

**Commonwealth of Massachusetts--Board of Registration in Medicine**
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

# POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Massachusetts Board of Registration in Medicine.

Applicant's Signature: M. Kwenzer Date: 5/7/99

Print or Type Name: MATTHIAS G. KWENZER, MD

Name of Institution: BETH ISRAEL DEACONESS MEDICAL CENTER

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registration in Medicine at the address above. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training to the Board.

Name of Institution: BETH ISRAEL DEACONESS MEDICAL CTR, BOSTON, MA

If name of institution was different when applicant attended, please enter name:

**Enrollment and Participation:** Our records indicate that MATTHIAS G. KWENZER MD participated in the following program:
(type or print applicant's name)

| Program Type (internship, residency, fellowship) | PGY (1,2,3,4) | Department (ObG, internal medicine, etc.) | Dates Attended (MONTH/DAY/YEAR) FROM | TO: | Completed (YES/NO) | Accredited By (ACGME, RSC, AOA or not accredited |
|---|---|---|---|---|---|---|
| RESIDENCY | PGY 1+3 | OB/GYN | 7 1 95 | 6 13097 | YES | ACGME |
| " | PGY 3+4 | " | 7 1 97 | 6 12099 | YES | ACGME |
| | | | / / | / / | | |
| | | | / / | / / | | |
| | | | / / | / / | | |

**POSTGRADUATE VERIFICATION**

Continued on back

**APPLICANT'S NAME:** MATTHIAS G. MUENZER MD

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

| **QUESTIONS** | **YES** | **NO** |
|---|---|---|
| 1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training? | | |
| 2. Was the applicant ever placed on probation? | | |
| 3. Was the applicant ever disciplined or under investigation? | | |
| 4. Were any negative reports ever filed by instructors regarding the applicant? | | |
| 5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems? | | |

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: _____

**Certification:** I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: _____

Print Name: HENRY KLAPHOLZ, MEE, MD

Academic Title: Associate Professor.

Telephone: (617) 667-2285 Today's Date: 5, 13, 99

**AFFIX INSTITUTIONAL SEAL HERE**

**(If the institution does not have a seal, this form must be notarized)**

**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

RECEIVED
JUN 12 2002
Board of Registration in Medicine

**Before proceeding, *please read the instructions 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 $400.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

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

1. Current Status: Active  Registration No.: 160382  Renewal Date: 08/26/2002

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. Matthias G Muenzer

B) Home Address:

Home Phone:

Business Phone: ~~(617) 730-4369~~ (978) 388-5696

**Please make corrections** (type or print)

Other Name(s): ~~Muenzer~~

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

Business Address: SEACOAST OB/GYN, 24 MORRILL PL
City/Town: AMESBURY State: MA
Zip: 01913 Country: USA
Business Telephone: (978) 388-5696

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___) _____
**PLEASE NOTE: No P.O. Box addresses for home or business addresses.**

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

5.a) Name of Medical School:
Ludwig-Maximilians University
b) Year Graduated: 1983 M.D. c) Degree:

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| | 0 | FULL TIME |

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

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

9. a) Other states where you are now licensed to practice (Abbr.)
NJ
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: 6 / ___ (AP) 100 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
*If 999*, print name(s): _____

PRINT YOUR LAST NAME: MUENZER LICENSE NUMBER: 160382

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: PIAM 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) 20

B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 4 %

## 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? I WAS DROPPED FROM THE CASE | | |
| 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: 6/10/02

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

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

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING

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

# Physician Registration Renewal Application

RECEIVED 2004 JUN -9 PM 2:06 BOARD OF REGISTRATION IN MEDICINE

Rec 6-9-04

**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.:160382 Renewal Date:08/26/2004

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

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

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

3. A) Mailing/Business Address: Matthias G Muenzer NOT CORRECT

B) Home Address: CORRECT

Home Phone:

Business Phone: 781-391-2424

**Please make corrections** (print)

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

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

Business Address: 101 MAIN ST, SUITE 214
City/Town: MEDFORD State: MA
Zip: 02155 Country: USA
Business Telephone: (781) 391-2424

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: M
c) SS#:

5. a) Name of Medical School: Ludwig-Maximilians University
b) Year Graduated: 1981 c) Degree: M.D.

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

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

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

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

9. a) Other states where you are now licensed to practice (Abbr.)
FL NJ ~~NY~~
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: 581 ✓ (AP) 95 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: 381 ✓ (AP) 5 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: MUENZER LICENSE NUMBER: 160382

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

Insurer's name. (Required): PROMUTUAL Policy dates: From: 7/15/03 To: 7/15/05

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) 2 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).

IF YOU CONSIDER OB-GYN PRIMARY CARE THEN 100%, IF OB-GYN IS "SPECIALIST CARE" THEN ZERO %

1) Average weekly hours involved in: A) inpatient care 3 hrs/wk B) outpatient care 37 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 100 % 100% in OB-GYN

## 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: M. Muenzer Date: 5/12/04

**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.**

NATIONAL PROVIDER IDENTIFIER (NPI) REPORTING FORM

MS

PHYSICIAN: MATTHIAS G. MUENZER MD

NATIONAL PROVIDER IDENTIFIER (NPI) LIC# 160382

04/25/06 S1 7

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.

**Please select one option below:**

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.

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

☒ My current NPI is: 1689655839

☐ I have personally applied for an NPI.

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

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

**HIPAA TAXONOMY CODES**

Please provide the HIPAA taxonomy (specialty) codes (refer to the Taxonomy Codes and Additional NPI Information at the Board's website 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: | ☐☐☐☐☐☐☐☐☐☐ | allopathic physician |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | OB/Gyn |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | |

**NPI REQUIRED INFORMATION**

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number:

State of Birth (If US): _____ Country of Birth (if outside the US): GERMANY

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.

Signature: ✓ [signature] Date: 1/26/06

FAX COPY OF THIS FORM AND MAIL THE COMPLETED ORIGINAL FORM TO:
**Board of Registration in Medicine, 560 Harrison Avenue, G-4, Boston, Massachusetts 02118**

# Massachusetts Physician Renewal Application

**Physician Name:** Matthias G Muenzer **License No.:** 160382

## PART A

**1) Current Status:** Active **Renewal Due Date:** 07/29/2006 **Birth Date:**

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

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

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

**2a) MAILING ADDRESS**

RECEIVED
JUN 27 2006
Board of Registration in Medicine

☐ *Check here to change this address*

**Please make corrections** (print)

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

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

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

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**

Family Medical Assoc.
101 Main St. Ste 214
Medford, MA 02155

Phone: (781)391-2424

☐ *Check here to change this address*

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

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 781-391-6224

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

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

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



06/28/06 S1 16

# Massachusetts Physician Renewal Application

**Physician Name:** Matthias G Muenzer **License No.:** 160382

| *(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: | NJ FL |
| 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: Partnership or Group Practice Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 40

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

**No Affiliations** ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

| **Health Care Facility** *(See Renewal Instructions, page 4.)* | Delete? | Staff Category Current | Staff Category Change | *Approximate* # Hours per Week |
|---|---|---|---|---|
| Hallmark Health -Lawrence Memorial Hospital | ☐ | ACTIVE | | 1 |
| Melrose-Wakefield Hospital | ☐ | ACTIVE | | 10 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

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

Average weekly hours involved in: a) inpatient care 3 hrs/wk Change to: _____ hrs/wk

b) outpatient care 37 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: Promutual Insurance Change to: MARSH MANAGEMENT SERVICES CAYMAN

Policy dates: *(required)* From 10/01/05 To 10/01/06

☐ **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:** Matthias G Muenzer **License No.:** 160382

**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**<br>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?<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Are there any criminal charges pending against you today?<br>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



06/28/06 15:30 #91

# Massachusetts Physician Renewal Application

**Physician Name: Matthias G Muenzer** **License No.: 160382**

06/28/06 SJ 20

## 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: 6/25/06

**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: Matthias G Muenzer** **License No.: 160382**

## 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.

06/28/06 SM

**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: 1689655839

☐ I have personally applied for an NPI.

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

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

☐ 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 13 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: | ☐☐☐☐☐☐☐☐☐☐ | _____ |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | _____ |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | _____ |

## NPI REQUIRED INFORMATION

In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. **Please note:** This information is required if you authorize BORIM to apply for an NPI on your behalf.

Social Security Number: ☒☐☐ - ☐☐ - ☐☐☐☐

State of Birth (if US): _____ Country of Birth (if outside the US): _____

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.

**I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan, or health organization.**

Signature: _____ Date: 6/25/06

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

# Massachusetts Physician Renewal Application

**Physician Name:** Matthias G Muenzer, M.D. **License No.:** 160382

07/31/08 SS 1

## PART A

**1) Current Status:** Active **Renewal Due Date:** 07/29/2008 **Birth Date:**

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

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

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

**Please make corrections** (print)

**2a) MAILING ADDRESS**

✓

RECEIVED

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

**2b) HOME ADDRESS** JUL 3 0 2008

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**

~~Family Medical Assoc~~. ELL POND OB/GYN

101 Main St. Ste 214

Medford, MA 02155

✓

Phone: (781)391-2424

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___)_____

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 781-391-6224

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

_____

_____

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name:** Matthias G Muenzer, M.D. **License No.:** 160382

07/31/08 SS

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

**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?** |
|---|---|---|---|
| Hallmark Health -Lawrence Memorial Hospital | | | ☐ |
| Melrose-Wakefield Hospital | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 3 hrs/wk Change to: _____ hrs/wk

b) outpatient care 37 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: Marsh Management Services Cayman Change to: _____

Policy dates: From 10/1/07 To 10/01/08 ANNUAL RENEWAL!

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: Matthias G Muenzer, M.D.** **License No.: 160382**

07/31/08 33 4

**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**<br>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).<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Have any criminal offenses/charges against you been resolved during this time period?<br>c) Are there any criminal charges pending against you today?<br>d) Are any Applications for Issuance of Process pending against you? | | |
| **18) INVESTIGATIONS AND DISCIPLINARY ACTIONS**<br>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?<br>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?<br>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?<br>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: Matthias G Muenzer, M.D.** **License No.: 160382**

07/31/08 33

## 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: 7/29/08

**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.**

07/31/08 33

## FREQUENTLY ASKED QUESTIONS
### REGARDING OFFICE BASED SURGERY- FORM PCA-O

**Question #1:**
"If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?"

*Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form it its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org*

**Question #2:**
"I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?"

*The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org*

**Question #3:**
"If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?"

*You only have to fill out the form if you perform office-based procedures in Massachusetts.*

**Question #4:**
"I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?"

*No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.*

**Question #5**
"I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?"

*You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.*

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

**Physician Name:** Matthias G Muenzer, M.D. **License No.:** 160382

**Current Status:** Active **License Expiration Date:** 8/26/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**
Ell Pond Ob/Gyn
101 Main St. Ste 214
Medford
Massachusetts - 02155
United States of America
(781) 391-2424

3) **Email Address:**

4) **Fax Number:** (781) 391-6224

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
Florida

9) **States where you were previously licensed**
New Jersey
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 |
|---|---|
| Hallmark Health -Lawrence Memorial Hospital | |

Melrose-Wakefield Hospital

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 6 hrs/wk
**b) outpatient care** 37 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Marsh Management Services Cayman | 10/01/2009 | 10/01/2010 | Occurrence Policy |

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

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

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

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

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

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

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

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

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

**Physician Name:** Matthias G Muenzer, M.D. **License No.:** 160382

22) **Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)** Yes

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

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

**Physician Name:** Matthias G Muenzer, M.D. **License No.:** 160382

## 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 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.

[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:** Matthias G Muenzer, M.D. **License No.:** 160382

**Current Status:** Active **License Expiration Date:** 8/26/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**

3) **Email Address:**

4) **Fax Number:** (781) 391-6224

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
Florida

9) **States where you were previously licensed**
New Jersey
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 |
|---|---|
| Hallmark Health -Lawrence Memorial Hospital | |

Melrose-Wakefield Hospital

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 6 hrs/wk
**b) outpatient care** 37 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Marsh Management Services Cayman | 10/01/2011 | 10/01/2012 | Occurrence Policy |

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

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

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

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

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

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

**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:** Matthias G Muenzer, M.D. **License No.:** 160382

**Current Status:** Active **License Expiration Date:** 8/26/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**
101 Main Street
Suite 217
Medford
Massachusetts - 02155
United States of America
(781) 391-2424

3) **Email Address:**

4) **Fax Number:** (781) 395-4703

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
Florida

9) **States where you were previously licensed**
New Jersey
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 |
|---|---|
| Hallmark Health -Lawrence Memorial Hospital | |

Melrose-Wakefield Hospital

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 6 hrs/wk
**b) outpatient care** 37 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Marsh Management Services Cayman | 10/01/2013 | 10/01/2014 | Occurrence Policy |

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

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

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

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

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

**18) Other Issues**
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
c) Have you been the subject of an investigation by any governmental authority, 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?** | |
| **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:** Matthias G Muenzer, M.D. **License No.:** 160382

## 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.**