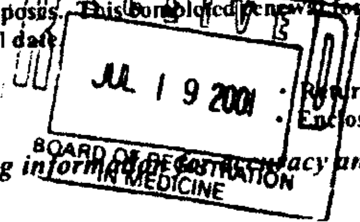
Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

# Physician Registration Renewal Application

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




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

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

REDACTED COPY

1. Current Status: Active    Registration No.: 48979    Renewal Date: 09/19/2001

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

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

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

3. A) Mailing/Business Address:
MAUREEN E PAUL
PLANNED PARENTHOOD LGE
1055 COMMONWEALTH AVENUE
BOSTON, MA 02215

B) Home Address:

Home Phone:

Business Phone: ~~(617)524-1241~~ (617) 616-1600

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

Other Name(s): ______

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

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

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

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

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

c) SS#:

5. a) Name of Medical School: Tufts University School of Medicine

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

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| GYN ~~OBG~~ | 21 ~~0~~ | ~~Obstetrics and~~ Gynecology |
| OM | 0 | Occupational Medicine |

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

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

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

b) States where you were previously licensed (Abbr.)
___ ___ WA CT ___

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: 533/✓ (AP) 0 %  Facility Code: 996/__ (AP) 100 %  Facility Code: ___/___ (AP) ___%
Facility Code: 441/✓ (AP) 0 %  Facility Code: ___/___ (AP) ___%  Facility Code: ___/___ (AP) ___%
If 999, print name(s): ______

PRINT YOUR LAST NAME: ______________________ LICENSE NUMBER: ____________

11. My medical malpractice insurance is covered by a) [x] Insurance Carrier b) [ ] Letter of Credit
Name of Insurer: Aon Risk Services Inc of New York 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 [x] No

13. A. What is your principal work setting? (See Table 4) 25

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

1) Average weekly hours involved in: a) outpatient care 21 hrs/wk b) inpatient care 0 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

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

YES NO

14. CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?

15. CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?

16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?

17. Have you been charged with any criminal offense, other than a minor traffic violation?

18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?

19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?

20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?

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

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? [x] 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: Maureen Paul Date: 7/12/01

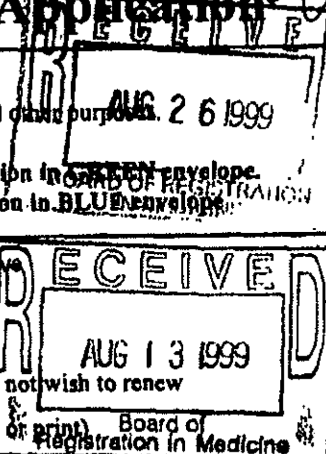
**YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION**

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

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

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

# Physician Registration Renewal Application





**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.: 48979 Renewal Date: 09/19/1999 1. Current Status: Active

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

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

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

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

Other Name(s): ______

3. A) Mailing/Business Address:
MAUREEN E PAUL
PLANNED PARENTHOOD LGE
1055 COMMONWEALTH AVENUE
BOSTON, MA 02215

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

B) Home Address:

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

Home Phone:
Business Phone:

Home: (____)______
Business: (617) 616-1631 ✓

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

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

5. A) Name of Medical School:
Tufts University School of Medicine

B) Year Graduated: 1979 C) Degree: M.D.

Full Name of Medical School: ______

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

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| OM | 0 | Occupational Medicine |

| Code(s) | Hours Per Week in Massachusetts |
|---|---|
| OBG | 40 |
| OM | 0 |

If OS, Print Specialty: ______ ✓

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

Code: OG Code: PM02

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

Federal (DEA): ______
Mass: ______

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

Abbr: CT __ __
Abbr: __ __ __

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

PRINT NAME AND NUMBER: Last Name: PAUL Registration Number: 48979

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: 441/1% (AP) ✓ % Facility Code: 996/90% (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: 533/9% (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: Investors Insurance Co + Nat'l Union Fire Ins. Co. of Pittsburg Alternatively, indicate as follows: → see attached sheet

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) 2 5

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

1) Average weekly hours involved in: a) outpatient care 26 hrs/wk b) inpatient care 3 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: Maureen Paul MD Date: 7/27/99

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

**DIVISION OF REGISTRATION**
ROOM 1520 — 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
BOARD OF REGISTRATION
IN MEDICINE

AS A REGISTERED
PHYSICIAN

**IMPORTANT — READ, COMPLETE AND SIGN —**
PURSUANT TO M.G.L. C.62C, S.49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC. SEC NO OR FEDERAL ID NO

YOU MUST SIGN BELOW

x Maureen E Paul
APPLICANT'S SIGNATURE

MY SIGNATURE ON THIS RENEWAL APPLICATION INDICATES THAT I ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY TO THE COMPLETION OF CONTINUING EDUCATION REQUIREMENTS IN COMPLIANCE WITH THE BOARD'S STATUTES AND/OR RULES AND REGULATIONS.

| LICENSE NUMBER | | | PAY THIS AMOUNT | FEE | DATE TO BE RENEWED | | | LATE FEE |
|---|---|---|---|---|---|---|---|---|
| CODE | TYPE | REGISTRATION NO. | | | MO | DA | YR | |
| MD | | 48979 | 100.00 | 100.00 | 01 | 15 | 84 | |

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT FOLD OR STAPLE THIS FORM

MAUREEN E PAUL

147 MASON TERRACE
BROOKLINE, MA. 02146

DO NOT WRITE BELOW THIS LINE

PLEASE USE THE ENCLOSED RETURN ENVELOPE

Note! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A CERTIFIED CHECK OR MONEY ORDER — PAYABLE TO:

COMM. OF MASS.
P.O. BOX 8
BOSTON, MASS. 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

3500600489799 011584 10000000009

1. Principal Specialty(ies): * | 3 | 0 | | ■ | ■ |

2. Principal work setting: * | 3 | 7 |

3. Home Address:

4. Primary work address: ST. MARGARET'S HOSPITAL 90 CUSHING AV. DORCHESTER, MA 02125

5. States other than Massachusetts in which you are licensed to practice: N/A

| | YES | NO |
|---|---|---|
| 6. Has a judgement been returned against you in a malpractice suit since 1/15/82? | | |
| 7. Have you ever been convicted of any criminal offense other than minor traffic offenses? | | |
| 8. Has any disciplinary action been taken against you in this state or any other? | | |
| 9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? | | |

10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows: * | 0 | 6 |

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE. Maureen E Paul

SIGNATURE

* SEE CODE SHEET

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

## I. PHYSICIAN INFORMATION

MAUREEN — *First Name*
E — *Middle Initial*
PAUL — *Last Name*
*Suffix*

*Make changes to name here*

Mass License # 48979
License Status Active

First Issue Date 08/02/82

The Med. Ctr.-Memorial
119 Belmont Street
Worcester, MA 01605
U.S.A.
(508) 793-6255

**Hospital Affiliation**

University of Massachusetts Med Center
~~Clinic~~
Med Ctr of Central Mass-Worc ~~Hahnemann~~

*Make address corrections here:*

*Make any corrections to above here:*
Med Ctr of Central Mass - Worc Memorial

**Insurance Plan Affiliation:**
Blue Cross - Blue Shield
Pilgrim
CHHC

**Licenses Held in Other States:**

*(Please correct as necessary)*

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

## II. EDUCATION & TRAINING

| Medical School | Degree | Date |
|---|---|---|
| Tufts University School of Medicine | MD | 79 |

*Make corrections here*

| Residency Program(s) | Start | End |
|---|---|---|
| UNIV. OF WASHINGTON OB-GYN | 1979 | 1981 |
| TUFTS UNIVERSITY OB-GYN | 1981 | 1984 |
| UNIV. OF MASSACHUSETTS - OCCUPATIONAL MEDICINE | 1987 | 1988 |

## III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology
Secondary Specialty: Occupational Medicine

*Make any corrections here:*

## BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology
Certifying Board Name: Board of Preventive Medicine

*Make any corrections here:*

## IV. BOARD DISCIPLINE

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

| Nature | Date | Board Action |
|---|---|---|

## V. HOSPITAL DISCIPLINE

| Hospital | Date | Disciplinary Action |
|---|---|---|

## VI. CRIMINAL CONVICTIONS

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

## VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. PAUL

| Date | Amount Paid | Basis for Complaint |
|---|---|---|
| | 0.0000 | |
| | | |
| | | |
| | | |
| | | |
| | | |

## VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

**Awards, Honors**

AMERICAN MEDICAL WOMEN'S ASSOCIATION REPRODUCTIVE HEALTH AWARD 1994

**Publications**

1. OBSTETRICS + GYNECOLOGY
2. AMER. JOURNAL OF INDUSTRIAL MEDICINE
3. JOURNAL OF NAT'L CANCER INSTITUTE
4. PRIMARY CARE
5. SEMINARS IN PERINATOLOGY
6. ENVIRONMENTAL HEALTH PERSPECTIVES

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

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

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

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| 48979 | ACTIVE | $250.00 | 09/19/95 | $25.00 |

Mailing Address:

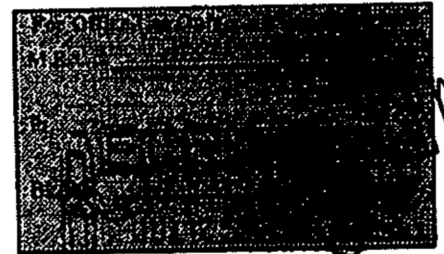
MAUREEN E PAUL, M.D.

**Correction of Mailing Address**

Address (Mailing): DIVISION OF REPRODUCTIVE MEDICINE MCCH/MEMORIAL - 119 BELMONT ST.
City/Town: WORCESTER
State: MA. 01605
Country: USA

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

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



BOARD OF REGISTRATION IN MEDICINE

**Pre-Printed Information**

1. Other name(s), if any, under which you were licensed:
2. Business Address:
   UNIV OF MASS MED CTR
   55 LAKE AVENUE N
   WORCESTER, MA 01655
3. Date of Birth: Sex: F
   Lic. Issue Date: 03/02/82 SS#:

   Home Phone / Business Phone
   (508)793-6266
4. Name of Medical School:
   Tufts University School of Medicine
   Year Graduated: 79 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr):
   b) States where you previously were licensed to practice (Abbr): WA
6. Specialty Code(s) (See Table 1):

| Code | Hours per Week in Mass. | |
|---|---|---|
| OBG | 30 | Obstetrics and Gynecology |
| OM | 20 | Occupational Medicine |

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: OG Code: PM
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts

**Corrections of Pre-Printed Information**

Name: (NEW HOME ADDRESS AS OF 9/1/95)
Address:
City/Town:
State: Zip:
Country:

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

Home: Business: (508-793-6255

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code / Hours per Week in Mass.

If OS, print specialty:

Code: Code: PM03

Federal (DEA):
Mass:

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

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

PRINT NAME AND NUMBER: Physician Last Name: PAUL Registration Number: 48979

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

Facility Code: 841 / ✓ (AP) Facility Code: 996 / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 77 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

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

If 999, write name(s): ___

11. My medical malpractice insurance is covered by (a) Insurance Carrier ✓ (b) Letter of Credit ___ If applicable, check one.

List Insurer: ___

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

State how otherwise exempt: Univ. of Massachusetts Medical Center Self-Insurance Trust

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

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

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 15 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 25 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 50 %

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

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

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

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

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

Signature: Maureen Paul MD Date: 7/25/95

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

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| [illegible] | ACTIVE | $250.00 | 09/19/93 | $25.00 |

**Mailing Address:**
[illegible] PAULY, M.D.

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

**Directions: Staple check to bottom of form. Add late fee if necessary.**

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

For Office Use Only OCT 14 1993
M.R.
Pr. OCT 14 1993
Bk/D.E.

**Pre-Printed Information**

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

2. a) Address (Home):

   b) Address (Business):
   UNIV OF MASS MED CTR
   55 LAKE AVENUE N
   WORCESTER, MA 01655

3. Date of Birth: Sex: F
   Lic. Issue Date: [illegible] SS#:
   Telephone Number:
   Home
   Business
   (508)793-[illegible]

4. Name of Medical School:
   Tufts University School of Medicine

   Year Graduated: [illegible] Degree: MD

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

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

| Code | Hours per Week in Mass. | |
|---|---|---|
| [illegible] | [illegible] | Obstetrics and Gynecology |
| [illegible] | [illegible] | Occupational Medicine |

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

   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

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

**Corrections of Pre-Printed Information**

Name: ____________
Address (Home): ____________
City/Town: ____________
State: ____________ Zip: ____________
Country Code: ________ If 999 print Country: ____________
Address (Business): ____________
City/Town: ____________ 01655
Country Code: ________ If 999 print Country: ____________

Date of Birth (M/D/Y): __/__/__ Sex (M/F): ________
Lic. Issue Date (M/D/Y): __/__/__ SS#: ________
Telephone Number:
Home: ( ) ____________ Business: 508-793-6255

Full Name of Medical School: ____________

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

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

Code: ________ Code: ________

Code: ________ Code: ________

Federal (DEA): ____________
State (MA): ____________

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

**Staple Check Here**

PRINT NAME AND NUMBER: Physician Last Name: ______________ Registration Number: __________

10. Activity Status: I am applying to be registered with the following status: Active ✓ Inactive ___
- I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: UNIV. MASSACHUSETTS MEDICAL CENTER

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 8 4 1 / ✓ (AP) Facility Code: 9 9 6 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)
Facility Code: ___ 7 7 / ✓ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): ______________

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

If 999, write name(s): ______________

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

14. a) What is your principal work setting? (See Table 5) 1 0

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 12 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? [illegible] hrs/wk in MA

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

**IN THE PAST TWO YEARS:** YES NO

15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? .........

16. Have you been charged with any criminal offense, other than a minor traffic violation?........

17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?........

18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? ........

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? ........

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?

22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs? ........

23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?......

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

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

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

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

Signature: Maureen Paul MD Date: 10/14/93

# 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

8/5

Before proceeding, please read the instruction booklet.

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

Registration No.: 48979 Renewal Date: 09/19/97

CHT

1. Activity Status: (Check only one)
   - [x] Active
   - [ ] Inactive *(see below)
   - [ ] Retiring (see instructions)
   - [ ] Do not wish to renew

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

3. A) Mailing/Business Address:
   MAUREEN E PAUL, M.D.
   MEMORIAL HOSPITAL\OB GYN
   119 BELMONT STREET
   WORCESTER, MA 01605

   B) Home Address:

   Home Phone:
   Business Phone: (508)793-6255

4. A) Date of Birth: C) Sex: F
   B) Lic. Issue Date: 03/02/82 D) SS#:

5. A) Name of Medical School:
   Tufts University School of Medicine
   B) Year Graduated: 79 C) Degree: MD

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 30 | Obstetrics and Gynecology |
| OM | 20 | Occupational Medicine |

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

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

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

**Corrections (type or print)**

Other Name(s):

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

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

Home: (
Business: (508) 792-8463

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

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

| Code(s) | Hours Per Week in Mass. |
|---|---|
| OBG | 40 |
| OM | 10 |

If OS, Print Specialty:

Code: Code:

Federal (DEA):
Mass:

Abbr: CN

Abbr:

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

PRINT NAME AND NUMBER: Last Name: PAUL Registration Number: 48979

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

Facility Code: 539 / ✓ (AP) Facility Code: 996 / (AP) Facility Code: ___ / __ (AP)
Facility Code: 841 / ✓ (AP) Facility Code: ___ / __ (AP) Facility Code: ___ / __ (AP)
If 999, print name(s): ______

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

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

If 999, write Name(s): ______

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

Name of Insurer: The University of Massachusetts Self-Insurance Program

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one) a) ___ Not involved in direct/indirect patient care in Massachusetts b) ___ Otherwise exempt

Please explain exemption: ______

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

13\. A. What is your principal work setting? (See Table 4) 1 0

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

1) Average weekly hours involved in: a) outpatient care 16 hrs/wk b) inpatient care 17 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 20 %

# PART A

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

## IN THE PAST TWO (2) YEARS:

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

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

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

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

Signature Maureen Paul Date: 7/23/97

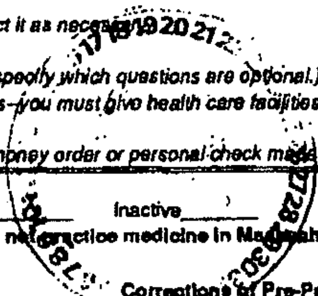
# Commonwealth of Massachusetts Board of Registration in Medicine
## Ten West Street, 3rd Floor, Boston, Massachusetts 02111
## 1991-1993 Physician Registration Renewal Application

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 45979 | ACTIVE | $150 | 09/19/91 |

Dr. MAUREEN E PAUL

For Office Use Only
M.R. ____ __/__/__
Pr. ____ __/__/__
Bk. ____ __/__/__
Ch. ____ DELIVERED AUG 3
D.E. ____ __/__/__

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



**Activity Status:**
I am applying to be registered with the following status: Active____ Inactive____
**I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.**

**Pre-Printed Information** / **Corrections of Pre-Printed Information**

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

Name:____

2. a) Address (Home):

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

2. b) Address (Business):
UNIV OF MASS MED CTR
55 LAKE AVENUE N
WORCESTER, MA 01605-

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

3. Date of Birth: Sex: F
Lic. Issue Date: 03/02/82 SSN #
Telephone Number:
Home
Business
(508)793-6255

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): ____
Lic. Issue Date(M/D/Y): ___/___/___ SSN #: ____
Home: (___)____ Business: 508 ) 793-6266

4. Medical School Code: MA007 Year Graduated: 79 Degree: MD
Name of School:
Tufts University School of Medicine

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

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

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

| Code | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| OM | 0 | Occupational Medicine |

| Code | Hours per Week in Mass. |
|---|---|
| ____ | 30 |
| ____ | 20 |

If OS, write specialty:____

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

Code:____
Code: PM

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

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

30M - 9/90 - P813971

[ *For Office Use Only: Waiver Granted____ Date: ___/___/___* ]

FILL IN NAME AND NUMBER:

Physician Last Name: Paul    Registration No.: 48979

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

List Insurer: The University of Massachusetts Self Insurance Program

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

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

*(State how otherwise exempt)*:____

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

Facility Code: 402/✓(AP)   Facility Code: 999/__(AP)   Facility Code: ___/__(AP)

Facility Code: 841/✓(AP)   Facility Code: ___/__(AP)   Facility Code: ___/__(AP)

*If 999, write* Name(s): Family Health and Social Service Center

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

Facility Code: 999   Facility Code: ___   Facility Code: ___   Facility Code: ___

*If 999, write* Name(s): Dorchester Neighborhood Health Center

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

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

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

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

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

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 25 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 10 hrs./wk. in MA.

14. Principal Work Setting.

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

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

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

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

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

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

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

Signature: Maureen Paul MD    Date 7/19/91

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

SOC. SEC. NUMBER, OPTIONAL

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

| LICENSE NUMBER CODE | TYPE | REGISTRATION NO. | PAY THIS AMOUNT | FEE | DATE TO BE RENEWED MO | DA | YR | LATE FEE |
|---|---|---|---|---|---|---|---|---|
| MD | 1 | 40979 | $100 | 100 | 09 | 19 | 87 | |

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

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

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

MAUREEN E PAUL

AUG 1987

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

1. Print Name: MAUREEN ELIZABETH PAUL
2. Date of Birth: MONTH DAY YEAR
3. Medical School: TUFTS UNIV. SCHOOL OF MEDICINE M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: U.S.A.
5. Date of Graduation: 6/1/79
6. American Specialty Board Certified? ☑ (Check if yes.)
   Which Boards? AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY
7. Principal Specialty(ies): OBSTETRICS AND GYNECOLOGY
8. Principal work setting: HOSPITAL
9. Home address: SAME AS ABOVE
10. Principal business address: UNIV. OF MASSACHUSETTS MED. CTR, 55 LAKE AV. N. - WORCESTER, MA. 01605
11. List all hospitals at which you have currently effective privileges: UNIV. OF MASSACHUSETTS MEDICAL CENTER
12. List all hospitals at which you have held privileges in the past 20 years: NEW ENGLAND MED. CTR. - ST. MARGARET'S HOSPITAL, NEWTON - WELLESLEY HOSPITAL
13. States other than Massachusetts in which you are presently licensed to practice: NONE
14. List any other states where you were previously licensed to practice: WASHINGTON

AUG 1987 RECEIVED

| | YES | NO |
|---|---|---|
| 15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time? | | |
| 19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason? | | |
| 20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever, for any reason, lost American Specialty Board Certification? | | |
| 24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)? | | |

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: ENROLLED IN APPROVED OCCUPATIONAL HEALTH RESIDENCY PROGRAM - UNIV. OF MASSACHUSETTS - WORCESTER, MA.
26. I am an active ☑ inactive ☐ practitioner. (Check One.)

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

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NOTE: THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

Maureen Paul
SIGNATURE

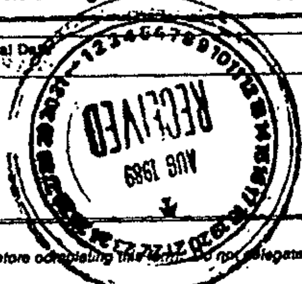
DATE: 8/7/87

(See Reverse Side)

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

014911

Board Use Only:
Registration No. | Status | Fee $150 | Renewal Date



M.R.
Pr.
Bk.
Ch.
D.E.
Fl.

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

1. a) Name (LAST:) Paul (FIRST:) Maureen (M.I.:) E.

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

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

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

2. c) Address (Business): Department of Obstetrics and Gynecology, University of Massachusetts Medical Center
55 Lake Avenue North, Worcester, MA 01655

2. d) Telephone (Business): (508 ) 793 -6255 Extension --- 2. e) Telephone (Home) *(Optional)*: ( )

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

6. a) Medical School Code *(See Table 1)*: MA 007 *If 99999, write Name*:

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

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

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

| | | | | | |
|---|---|---|---|---|---|
| (10) Hospital | 100 % | 15 Private Office | ___ % | 20 Partnership/Group Practice | ___ % |
| 25 Clinic | ___ % | 30 Mental Health Center | ___ % | 35 Nursing Home | ___ % |
| 40 HMO Facility | ___ % | 45 Educational Institution | ___ % | 60 Medical Society | ___ % |
| 55 Government Facility | ___ % | 80 Plant/Commercial Setting | ___ % | 99 Other | ___ % |

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

| | | | |
|---|---|---|---|
| 10 Resident or Fellow | ___ % | (20) Practice Involving Direct Patient Care | 50 % |
| (30) Administrative Activities | 10 % | (40) Medical Teaching | 20 % |
| (50) Medical Research | 20 % | 99 Other | ___ % |

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 3/2/82

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 65 % Specialty Code: OM Percent of Practice Time: 35 %
*If OS, specify*:

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

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

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

Facility Code: 841 50 % Facility Code: ___ ___ % Facility Code: ___ ___ %
Facility Code: 402 50 % Facility Code: ___ ___ % Facility Code: ___ ___ %

*If 999, write Name(s)*:

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

Facility Code: 299 Facility Code: 065 Facility Code: 075 Facility Code: ___ Facility Code: ___

*If 999, write Name(s)*:

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

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

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) 2 attached pages--is true.

Signature: Maureen Paul MD Date: 8/1/89

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

*Fill in name and number.* **Physician Last Name:** Paul **Registration No.:** 48979

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

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

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

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 328 hrs., Category II: 20 hrs., (Risk-Management: 10 hrs.); Residency Program in: ___
Waiver Requested ___ (You must fill out a separate Waiver Form.)

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

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

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

15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? .........

16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? .........

17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? .........

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

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

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? .........

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? .........

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? .........

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? .........

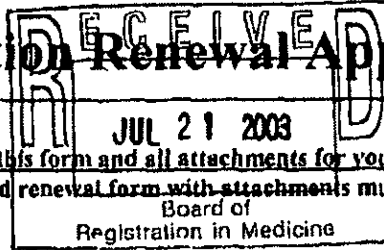
22. Are you now, or have you been in the past, dependent upon alcohol or drugs? .........

23. Have you, for any reason, lost American Specialty Board Certification? .........

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ .........

**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




0721030025I

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.:48979    Renewal Date:09/19/2003

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

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

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

3. A) Mailing/Business Address:
MAUREEN E PAUL
Planned Parenthood Golden Gate
815 Eddy St., # 300
San Francisco, CA 94109

B) Home Address:

Home Phone:

Business Phone: (415)441-7858

**Please make corrections (print)**

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

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

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

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

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

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

5. a) Name of Medical School:
Tufts University School of Medicine
b) Year Graduated: 1979    c) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| ~~OM~~ | ~~0~~ | ~~Occupational Medicine~~ |

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

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

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

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: __ __ __/__ (AP) ____ % Facility Code: __ __ __/__ (AP) ____ % Facility Code: __ __ __/__ (AP) ____ %
Facility Code: __ __ __/__ (AP) ____ % Facility Code: __ __ __/__ (AP) ____ % Facility Code: __ __ __/__ (AP) ____ %
If 999, print name(s): ______

PRINT YOUR LAST NAME: ______________________ LICENSE NUMBER: ____________

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

    Insurer's name. (Required): ______________________ Policy dates: From: ___/___/___ To: ___/___/___

    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) ____ ____ If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

## 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: Maureen Dane Date: 7/15/03

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

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

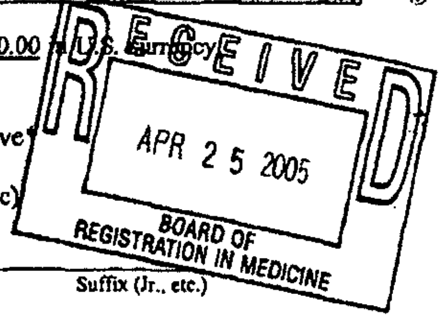
**MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.**

ck # 1528
(EM)

MA License Number: 48979
Date license revived: 7/19/05

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

## LAPSED LICENSE APPLICATION




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

**Activity Status:** ☑ Active ☐ Inactive*

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

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

**Medical Degree:** ☑ 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 ☐

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

Date of Birth: ___ ___ ___ Social Security Number: ___ ___ ___
Month Day Year

Place of Birth: WORCESTER MASSACHUSETTS
City State/Province/Territory Country if not USA

Home Address: ______
Number and Street

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

Business Address: 815 EDDY STREET - SUITE 300
Number and Street

SAN FRANCISCO CALIFORNIA 94109
City State/Province/Territory Zip (or postal) Code

Business Telephone: (415) 202-7220, ext. — Home Telephone: ______

Preferred Mailing Address: ☑ Business Address ☐ Home Address

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

*Inactive status: If you check inactive status when you sign the lapsed application, you certify that you will not practice medicine in Massachusetts.

APPLICANT'S NAME: MAUREEN ELIZABETH PAUL

**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.

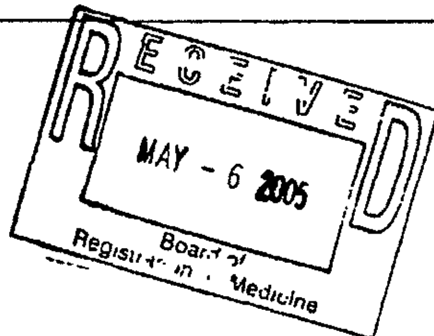
| Facility / Street | Position / City | From | To / State |
|---|---|---|---|
| Facility: TUFTS UNIV. SCHOOL OF MEDICINE | Position: STUDENT | 07/01/75 | 06/13/79 |
| Street: 145 HARRISON AV. | City: BOSTON | | State: MA. 02111 |
| Facility: UNIV. OF WASHINGTON MEDICAL CTR. | Position: PGY 1-2 | 07/01/79 | 06/30/81 |
| Street: 1959 NE PACIFIC | City: SEATTLE | | State: WA. 98195 |
| Facility: TUFTS NEW ENGLAND MEDICAL CTR. | Position: PGY 2-4 | 07/01/81 | 06/30/84 |
| Street: 750 WASHINGTON ST. | City: BOSTON | | State: MA. 02111 |
| Facility: UNIV. OF MASSACHUSETTS MEDICAL CTR. | Position: PGY 1 | 01/01/87 | 12/31/87 |
| Street: 55 LAKE AV. N. | City: WORCESTER | | State: MA. 01655 |
| Facility: BOSTON UNIV. SCHOOL OF PUBLIC HEALTH | Position: STUDENT | 09/ /84 | 05/15/88 |
| Street: 750 ALBANY ST. (TALBOT BLDG) | City: BOSTON | | State: MA. 02118 |

**Hospital Affiliations and Employment**

List in chronological order all 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. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

| Facility / Street | Position / City | From | To / State |
|---|---|---|---|
| Facility: NEW ENGLAND MEDICAL CENTER | Position: FACULTY PHYSICIAN | 08/01/84 | 12/31/86 |
| Street: 750 WASHINGTON ST. | City: BOSTON | | State: MA 02111 |
| Facility: UMASS MEMORIAL HEALTH CARE | Position: FACULTY STAFF MD | 01/01/88 | 06/27/01 |
| Street: 119 BELMONT ST. | City: WORCESTER | | State: MA. 01605 |
| Facility: PLANNED PARENTHOOD LEAGUE OF MA. | Position: MD + MEDICAL DIRECTOR | 07/01/98 | 05/18/02 |
| Street: 1055 COMMONWEALTH AV. | City: BOSTON | | State: MA. 02215 |
| Facility: BETH ISRAEL DEACONESS MEDICAL CTR. | Position: COURTESY PRIVILEGES | 12/07/01 | 06/01/02 |
| Street: 375 LONGWOOD AV. | City: BOSTON | | State: MA. 02115 |

SEE ATTACHED PAGE



**APPLICANT'S NAME:** **Maureen Elizabeth Paul**

Hospital Affiliations and Employment (continued)

Facility: Planned Parenthood Golden Gate
815 Eddy Street, San Francisco, CA. 94109
Position: Chief Medical Officer
From 07/01/02 to Present

Facility: San Francisco General Hospital
1001 Potrero Av., San Francisco, CA. 94110
Position: Courtesy Privileges
From 12/17/02 to 01/20/04

Facility: UCSF Mt. Zion Medical Center
1600 Divisadero St., San Francisco, CA. 94115
Position: Attending
From 11/30/04 to Present

07/28/05 23 19

APPLICANT'S NAME: MAUREEN ELIZABETH PAUL

**Medical Malpractice Information:**

My medical malpractice insurance coverage is by: ☑ Insurance carrier ☐ Letter of Credit

Print name of insurer: NATIONAL UNION FIRE INSURANCE CO.

Policy dates: From: 12/31/04 To: 12/31/05

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because: ☐ I am not involved in direct patient care ☐ Otherwise exempt

Explain exemption: ______

**Continuing Medical Education Credits**

Read instructions for continuing medical education requirements before completing.

Activity status: ☑ Active ☐ Inactive ☐ Exemption ______

Category 1 credits 113 Category 2 credits ____ Risk management Category 1 8 Category 2 2

Continuing medical education credit requirements must be completed before the Lapsed License can be revived.

1. List other states (abbreviations) where you are currently or have ever been licensed: CA AR CT WA
2. Are you certified by the American Board of Medical Specialties (ABMS)? ☑ Yes ☐ No
3. List only ABMS certification(s): OBSTETRICS + GYNECOLOGY OCCUPATIONAL MEDICINE
4. Reason for reviving Lapsed License in Massachusetts: MOVING BACK TO THE NORTHEAST

**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 pains and penalties of perjury.

Maureen Paul
Signature of Applicant

04-19-2005
Date

**Lapsdapplication-10/07/2002**

# CURRICULUM VITAE

## Maureen E. Paul, M.D., M.P.H.

### CURRENT POSITION

Chief Medical Officer
Planned Parenthood Golden Gate
815 Eddy St., 3rd Floor
San Francisco, CA 94109
415/202-7220

### COLLEGE & GRADUATE EDUCATION

| | |
|---|---|
| 1988 | Boston University School of Public Health, Boston, MA, --M.P.H. – Epidemiology and Environmental Health |
| 1979 | Tufts University School of Medicine, Boston, MA – M.D. |
| 1975 | University of Washington, Seattle, WA – B.S. |

### RESIDENCIES

| | |
|---|---|
| 1987 | University of Massachusetts Medical School, Worcester, MA<br>Resident in Occupational Medicine |
| 1981-84 | Tufts New England Medical Center, Boston, MA<br>Resident in Obstetrics and Gynecology (PGY2-4) |
| 1979-1981 | University of Washington Medical Center, Seattle, WA<br>Resident in Obstetrics and Gynecology (PGY1-2) |

### LICENSES & CERTIFICATIONS

#### *Licenses*

| | |
|---|---|
| California Medical License (G86493) | expires 9/30/05 |
| Massachusetts Medical License (48979) | expired 9/19/03 |
| Arkansas Medical License (E-3126) | expired 9/30/03 |
| DEA Certificate (AP8758293) | expires 3/31/08 |

#### *Board Certifications*

| | |
|---|---|
| 1990 | American Board of Preventative Medicine (Occupational Medicine) |
| 1986 | American Board of Obstetrics and Gynecology<br>Recertified 1996, with annual voluntary recertifications in 1999, 2000, 2001, 2002, 2003, and 2004 |

### EMPLOYMENT

| | |
|---|---|
| 2002-present | Chief Medical Officer<br>Planned Parenthood Golden Gate, San Francisco, CA |
| 2000-2002 | Staff Gynecologist and Director of Resident Training<br>Planned Parenthood League of Massachusetts |

| | |
|---|---|
| 1998–2000 | Medical Director<br>Parenthood League of Massachusetts |
| 1988-1998 | Faculty Physician, Dept. of Obstetrics & Gynecology<br>University of Massachusetts Medical Center, Worcester, MA |
| 1984-1986 | Faculty Physician, Dept. of Obstetrics & Gynecology<br>Tufts New England Medical Center, Boston, MA |

### Academic Appointments

University of California, San Francisco

| | |
|---|---|
| 2003-present | Associate Clinical Professor<br>Department of Obstetrics, Gynecology and Reproductive Sciences |

University of Massachusetts Medical School

| | |
|---|---|
| 1993-2002 | Associate Professor<br>Departments of Obstetrics & Gynecology and Family & Community Medicine |
| 1988-1992 | Assistant Professor<br>Department of Obstetrics & Gynecology and Family & Community Medicine |

Tufts University School of Medicine

| | |
|---|---|
| 1984-1986 | Assistant Professor<br>Department of Obstetrics and Gynecology |

## HONORS AND AWARDS

| | |
|---|---|
| 2001 | Medical Students for Choice Outstanding Research Award<br>"Early Surgical Abortion: Safety and Efficacy" |
| 2001 | National Abortion Federation/Ortho-McNeil Scientific Paper Award<br>"Is Pathology Examination Useful after Early Surgical Abortion?" |
| 2000 | Voters for Choice/Gloria Steinem Reproductive Freedom Award |
| 1999 | Distinguished Alumni Award<br>Boston University School of Public Health |
| 1994 | Reproductive Health Award<br>American Medical Women's Association |
| 1984 | George W. Mitchell Award<br>(for highest score on CREOG examination)<br>Tufts University School of Medicine |
| 1981 | Phi Beta Kappa<br>University of Washington |

## PROFESSIONAL ACTIVITIES

### *Membership in Professional Organizations*

| | |
|---|---|
| 1998-present | Physicians for Reproductive Choice and Health |
| 1997-present | Association of Physicians in Reproductive Health |

| | |
|---|---|
| 1994-present | National Abortion Federation |
| 1985-present | American Public Health Association |
| 1981-present | American College of Obstetricians and Gynecologists (Fellow) |
| 2000-2003 | American College of Physician Executives |
| 1996-1999 | Association of Professors in Gynecology and Obstetrics/Council on Resident Education in Obstetrics and Gynecology |
| 1994-2003 | American Medical Women's Association |
| 1988-1999 | American College of Occupational and Environmental Medicine |
| 1988-1995 | Association of Occupational and Environmental Clinics |
| 1985-1989 | Society for Adolescent Medicine (New England Chapter) |

***Committee Appointments***

| | |
|---|---|
| 2005-present | Reproductive Health Access Project, Advisory Board |
| 2004-present | National Network of Abortion Funds, Advisory Board |
| 2002-present | National Medical Committee, Planned Parenthood Federation of America |
| 2002-present | Reproductive Options Education Consortium for Nursing, Advisory Board, Massachusetts General Hospital |
| 2001-2003 | University of California San Francisco Center for Reproductive Health Policy and Research, Advisory Committee |
| 1997-2000 | National Abortion Federation, Research Committee |
| 1995-2002 | National Abortion Federation, Board of Directors, (Chair 2000-02) |
| 1995-2000 | National Abortion Federation, Clinical Policies Committee |
| 1995 & 1999 | National Abortion Federation, Strategic Planning Committee |
| 1994-2002 | Massachusetts Department of Public Health, Abortion Advisory Board |
| 1994-1997 | Boston University Environmental Hazards Center, Board of Advisors |
| 1993 | U.S. Public Health Service, Agency for Toxic Substances and Disease Registry, Scientific Committee on Reproductive Biomarkers |
| 1993 | U.S. Public Health Service, Agency for Toxic Substances and Disease Registry Scientific Committee to Assist in Developing a Standardized Test Battery for Birth Defects and Reproductive Disorders for Use in Environmental Health Field Studies |
| 1992-1996 | American College of Occupational and Environmental Medicine, Environmental Medicine Committee |
| 1992-1995 | NYU Medical Center, Board of Advisors, "Guide to Staying Healthy In A Risky Environment" |
| 1990-1992 | March of Dimes Birth Defects Foundation, Board of Directors, Massachusetts Chapter |
| 1989-1990 | Conte Institute for Environmental Health, Scientific Committee on Reproductive Risk Assessment |

| | |
|---|---|
| 1988-1990 | March of Dimes Birth Defects Foundation, Health Professional Advisory Committee, Massachusetts Chapter |
| 1988-1990 | Massachusetts Department of Public Health, Occupational Reproductive Hazards Policy Task Force |
| 1988-1989 | March of Dimes Birth Defects Foundation: Chair, Occupational Health Committee: Massachusetts/New Hampshire |
| 1985-1986 | Health Research Committee, Center for Environmental Management, Tufts University |
| 1985 | Massachusetts Department of Public Health, Committee for Review of Health and Environmental Problems in Woburn, MA |

### Service to Professional Publications

*ad hoc* reviewer for:

*Obstetrics and Gynecology*

*American Journal of Obstetrics and Gynecology*

*Reproductive Toxicology*

*Primary Care Medicine*

*International Journal of Occupational and Environmental Health*

*American Journal of Industrial Medicine*

reviewer for:

| | |
|---|---|
| 1993 | Institute of Medicine, "Environmental Medicine and the Medical School Curriculum" |

## INVITED PAPERS, LECTURES, PRESENTATIONS

### Invited Testimony

| | |
|---|---|
| August 5, 1994 | U.S. Senate Committee on Veterans Affairs, Hearing on Reproductive Hazards Associated with Military Service |

### Invited Lecturer

International

| | |
|---|---|
| 2000 | Pathfinder International |
| 1995 | Australasian College of Physicians & Surgeons and Australasian College of Occupational Medicine Combined Scientific Conference, Keynote speaker |

National

| | |
|---|---|
| 2001, 1992,1988 | American Public Health Association Annual Meeting |
| 1999 | American Medical Women's Association |
| 1995-2001 | Medical Students for Choice Annual Meeting |
| 1994 | New England College of Occupational and Environmental Medicine Annual Meeting |

| | |
|---|---|
| 1994 | U.S. Public Health Service, medical conference |
| 1994, 1993 | Organization of Teratology Information Services Annual Meeting |
| 1994, 93, 92 | American College of Occupational and Environmental Medicine Annual Meeting |
| 1993 | Perinatal Nurses Education Association Annual Meeting |
| 1992 | American Academy of Family Physicians/Lifetime Medical Television (television talk show participant) |
| 1992 | American Industrial Hygiene Association Annual Meeting |
| 1992 | Semiconductor Safety Association Annual Meeting |
| 1992 | Teratology Society Annual Meeting |
| 1990 | American College of Nurse Midwives Annual Meeting |
| 1990 | National Council on International Health, conference |
| 1990 | U.S. Environmental Protection Agency, medical conference |
| 1989 | American Association of Occupational Health Nurses Annual Meeting |
| 1989 | National Safety Council, conference |
| 1989 | U.S. Navy, Division of Occupational Health and Preventative Medicine, medical conference |
| 1988 | March of Dimes Birth Defects Foundation, medical conference |

State & Regional

| | |
|---|---|
| 2000, 2001, 2004 | University of Puerto Rico School of Medicine, Department of Obstetrics and Gynecology Grand Rounds |
| 2001, 1995 | Women and Infants Hospital, Department of Obstetrics and Gynecology Grand Rounds |
| 1997 | Massachusetts Association of Family Physicians Annual Meeting |
| 1997 | Massachusetts Department of Public Health, medical conference |
| 1996 | Maine Department of Public Health, medical conference |
| 1996 | St. Francis Hospital (Hartford, CT), Department of Obstetrics and Gynecology Grand Rounds |
| 1996 | St. Luke's Hospital/Roosevelt Medical Center (NYC), Department of Obstetrics and Gynecology Grand Rounds |
| 1996 | University of Utah School of Medicine, medical conference |
| 1995 | Alaska Nurse Practitioners Association Annual Meeting |
| 1995 | Hartford Hospital, Department of Obstetrics and Gynecology Grand Rounds |
| 1995 | Massachusetts Bar Association, conference |
| 1994, 92, 91 | University of Washington School of Medicine, medical conferences |

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|---|---|
| 1994 | Baystate Medical Center, Department of Obstetrics and Gynecology Grand Rounds |
| 1994 | New York Environmental Institute, medical conference |
| 1994 | Northeastern Industrial Hygiene Association Annual Meeting |
| 1994 | Philadelphia County Medical Society Annual Meeting |
| 1993 | Milwaukee Gynecological Society Annual Meeting |
| 1993 | New Hampshire Department of Public Health, medical conference |
| 1993 | New Jersey Occupational Medicine Association Annual Meeting |
| 1993 | Oregon Health Sciences University, medical conference |
| 1993 | Organization Resources Counselors, Inc., Washington DC, conference |
| 1992 | New Hampshire Safety Council Annual Meeting |
| 1992 | Ohio University, Department of Family Medicine, medical conference |
| 1992, 90, 89 | Berkshire Medical Center, Department of Obstetrics and Gynecology Grand Rounds |

<u>Local</u>

| | |
|---|---|
| 2005 | Contra Costa Medical Center, Department of Family Medicine Conference |
| 2004 | University of California, San Francisco, Department of Family & Community Medicine conference |
| 2004, 2003 | University of California, San Francisco, School of Medicine, Medical Students for Choice conference |
| 2004, 2003 | Stanford University School of Medicine, Medical Students for Choice Conference |
| 2003 | Natividad Medical Center, Department of Family Medicine conference |
| 2003 | Sutter Medical Center-Santa Rosa, Department of Family Medicine conference |
| 2002 | University of Massachusetts Memorial Medical Center, Department of Obstetrics and Gynecology Grand Rounds |
| 2001 | Tufts University School of Medicine, Department of Obstetrics and Gynecology Grand Rounds |
| 2000 | Cambridge Hospital, Department of OB-GYN Grand Rounds |
| 2000 | Massachusetts General Hospital, Interhospital Women's Health Grand Rounds |
| 1997 | Medical Center of Central Massachusetts, Department of Family Practice Grand Rounds |
| 1995 | University of Massachusetts Medical Student Forum on Abortion |
| 1995 | University of Massachusetts Women in Medicine Abortion Seminar |
| 1994 | Beth Israel Hospital (NYC), medical conference |

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|---|---|
| 1994 | Boston University School of Nurse Midwifery |
| 1994 | Worcester District Medical Society Annual Meeting |
| 1999, 1993 | Beth Israel Deaconess Medical Center (Boston), Department of Obstetrics and Gynecology Grand Rounds |
| 1991 | Greater Boston Occupational Health Nurses Association Annual Meeting |

## SERVICE

### *Community Service*

| | |
|---|---|
| 1992–2003 | Massachusetts Abortion Access Project, Co-founder and Member of the Board of Directors |
| 1999-2002 | Eastern Massachusetts Abortion Fund, Advisory Board |
| 1993-2000 | Massachusetts Teratology Information Services, Advisory Board |
| 1993 | National Environmental Birth Defects Registry, Advisory Board |
| 1992-2000 | Massachusetts Reproductive Rights Network |
| 1986-1995 | Massachusetts Toxics Network, Board of Directors |

### *Government Service*

| | |
|---|---|
| 1994 | Review Panel, Annual (MA) Governor's Award for Toxics Use Reduction |
| 1991 | Expert Consultant, U.S. General Accounting Office, Study Commissioned by the Senate Committee on Governmental Affairs, "Reproductive and Developmental Toxicants: Regulatory Actions Provide Uncertain Protection," |

### *University Service*

| | |
|---|---|
| 1994-1998 | University of Massachusetts Medical School, Medical Student Advisor |
| 1992-1996 | University of Massachusetts Memorial Hospital -- Women's Strategic Planning Committee |

## TEACHING

### *Residency Rotations*

| | |
|---|---|
| 2005-present | Director, Planned Parenthood Golden Gate-Contra Costa Medical Center Early Abortion Rotation for Family Medicine Residents |
| 2004-present | Director, Planned Parenthood Golden Gate-University of California San Francisco, Early Abortion Rotation for Family Medicine Residents |
| 2003-present | Director, Planned Parenthood Golden Gate-Sutter Medical Center/Santa Rosa, Early Abortion Rotation for Family Medicine Residents |
| 2003-present | Co-Director, Planned Parenthood Mar Monte-Natividad Medical Center Early Abortion Rotation for Family Medicine Residents |
| 2000-2001 | Director, Planned Parenthood League of Massachusetts-Baystate Medical Center, Abortion and Family Planning Rotation for OB-GYN Residents |

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|---|---|
| 1995-1998 | Director, University of Massachusetts Medical Center-Planned Parenthood League of Massachusetts, Abortion and Family Planning Rotation for OB-GYN Residents |
| 1989-1994 | Director, University of Massachusetts Medical Center, Elective Rotation Occupational & Environmental Reproductive Hazards Center |

### *Course Faculty*

Planned Parenthood Federation of America, Medical Directors Council, Scientific Meeting

| | |
|---|---|
| 2005 | Seminar, *Challenging Cases in Reproductive Healthcare* |

American College of Obstetricians and Gynecologists Annual Meetings

| | |
|---|---|
| 2001 | Postgraduate 060 Course, *Recent Advances in Contraception and Abortion* |
| 2000 | Postgraduate 060 Course, *Emerging Issues in Contraception and Abortion* |
| 1999 | Postgraduate 060 Course, *Induced Abortion: Modern Methods and Practices* |
| 1998 | Postgraduate 060 Course, *New Developments in Medical and Surgical Abortion* |
| 1997 | Clinical Seminar, *Medical Termination of Pregnancy* |
| 1995, 1994 | Clinical Seminar, *Pregnant Women in the Workplace: Assessing the Hazards* |
| various dates | Luncheon Conferences 1986, 1988, 1989, 1991, 1992, 1993, 1994, 1995, 1997 |

American College of Occupational and Environmental Medicine

| | |
|---|---|
| 1994, 1993 | Environmental Medicine Core Curriculum Course |
| 1989 | Postgraduate course, *Reproductive Hazards in the Workplace* |

American Medical Women's Association

| | |
|---|---|
| 1994-1996 | Master Faculty, Reproductive Health Initiative |

Australasian College of Occupational Medicine

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|---|---|
| 1995 | Training Course on Occupational Reproductive Hazards, Brisbane, Australia |

Boston University School of Public Health

| | |
|---|---|
| 1990 - 1993 | Reproductive Epidemiology Course |

Harvard School of Public Health

| | |
|---|---|
| 1990-91, 93-95 | Occupational Medicine Course |

National Abortion Federation

| | |
|---|---|
| 2001 | Risk Management Seminar, *Re-examining Abortion Practices: Integrating Experience and Research* |
| 2000 | Risk Management Seminar, *Misoprostol for Cervical Ripening and Abortion* |
| 1999 | Co-Chair, Postgraduate Course, *Abortion: Spotlight on Progress* |
| 1998 | Postgraduate Course, *First Trimester Surgical Abortion* |
| 1996 | Risk Management Seminar, *Clinical Policy Guidelines: Ensuring Quality Care* |
| 1995 | Co-chair, Postgraduate Seminar on Medical Abortion |

National Institute for Occupational Safety and Health

| | |
|---|---|
| 1994, 1993 | Course Director, *Educating Physicians in Occupational Health and the Environment* |

Organization of Teratology Information Services

| | |
|---|---|
| 1994 | Course on Occupational and Environmental Reproductive Hazards |

University of Massachusetts Medical Center – Core Curriculum for OB/GYN Residents

| | |
|---|---|
| 1996, 1993 | Induced Abortion |
| 1993 | Occupational Reproductive Hazards |

University of Massachusetts Medical School

| | |
|---|---|
| 1997 | Elective on "Abortion and Reproductive Choice" |
| 1994 | Toxicology Course |
| 1992, 89, 88 | Occupational Health and Safety Institute |
| 1991- 94 | Maternal Child Health Clerkship (quarterly) |
| 1989 | Hazard Reduction and Control in Hospitals |
| 1988-1998 | OB-GYN Clerkship (3rd Year Medical Students) |

University of Massachusetts School of Public Health

| | |
|---|---|
| 1996, 1994 | Occupational Medicine Course |

## RESEARCH

Research Experience, Awards, and Funding (If supported, funding listed in parentheses)

| | |
|---|---|
| 2005 | Co-Principal Investigator, University of California, San Francisco, "Expanded Pregnancy Care by Advanced Practice Nurses Project", John B. Merck Fund ($75,000), Educational Foundation of America ($140,000) |

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|---|---|
| 2004 | Principal Investigator, Planned Parenthood Golden Gate, "Manual Vacuum Aspiration Training Project for Advanced Practice Clinicians", Planned Parenthood Federation of America ($35,000) |
| 2003-present | Co-Principal Investigator and Director, University of California, San Francisco and Planned Parenthood Golden Gate, "Training in Early Abortion for Comprehensive Healthcare (TEACH) Project", Buffet Foundation ($650,000), Schiro Foundation ($30,000), Gold Fund ($50,000) |
| 2001 | Medical Students for Choice Outstanding Research Award "Early Surgical Abortion: Safety and Efficacy" |
| 2001 | National Abortion Federation/Ortho-McNeil Scientific Paper Award "Is Pathology Examination Useful after Early Surgical Abortion?" |
| 2000-2001 | Principal Investigator and Director, "Massachusetts Abortion and Family Planning Training Initiative", Kenneth J. Ryan Residency Training Program in Abortion and Family Planning, Buffet Foundation, ($90,000) |
| 1998--1999 | Co-Principal Investigator, "Methotrexate and Misoprostol for Early Abortion", Planned Parenthood Federation of America |
| 1997 | Principal Investigator, Innovations in Medicine Education Grant, "Integrating Abortion and Reproductive Choice into Medical School Curricula", University of Massachusetts Medical School ($2,000) |
| 1996-1998 | Principal Investigator, "Efficacy and Safety of Misoprostol for Induction of Labor" |
| 1995-1997 | Principal Investigator, Abortion Training and Advocacy Initiative, Jessie B. Cox Trust and John B. Merck Fund (Trust and Fund contributed equally to a total funding of $240,000) |
| 1994-1997 | Co-Investigator, Academic Award in Occupational and Environmental Medicine, National Institute of Environmental Health Sciences ($125,000 per year) |
| 1993-1994 | Principal Investigator, "Educating Physicians in Occupational Health and the Environment (EPOCH-Envi)", National Institute for Occupational Safety and Health |
| 1992-1993 | Co-Principal Investigator, "Corporate Reproductive Hazards Policies: Follow-up to the Family, Work, and Health Survey," |
| 1991-1992 | Principal Investigator, "Occupational and Environmental Reproductive Hazards Center/Community Education Project," March of Dimes Birth Defects Foundation |
| 1991-1992 | Principal Investigator, "Occupational Electromagnetic Field Exposures in a Neonatal Intensive Care Nursery," |
| 1991 | Principal Investigator, "National Working Conference on Occupational and Environmental Reproductive Hazards," Ruth Mott Fund, March of Dimes Birth Defects Foundation, Agency for Toxic Substances and Disease Registry (U.S. Public Health Service) (approximately $60,000) |

| | |
|---|---|
| 1990-1992 | Principal Investigator, "Uterine Activity during Physical Work Tasks as Assessed by Ambulatory Uterine Monitoring", March of Dimes Birth Defects Foundation ($60,000) |
| 1989-1990 | Principal Investigator, "Analysis of Reproductive Health Effects Information on Material Safety Data Sheets" |
| 1989-1990 | Principal Investigator, "Occupational and Environmental Reproductive Hazards Center," March of Dimes Birth Defects Foundation and Ruth Mott Fund, (approximately $50,000) |
| 1988-1989 | Consultant, "Environmental Tobacco Smoke During Pregnancy and Carcinogen- Hemoglobin Adducts in Maternal and Cord Blood", March of Dimes Birth Defects Foundation |
| 1988 | Principal Investigator, "Family, Work, and Health Survey" |

## PUBLICATIONS

### *Articles in Peer-Reviewed Journals*

**Paul ME**: *Worker reproductive fitness and risk.* Occupational Medicine: State of the Art Reviews. 1988; 3:329-340

**Paul ME**, Himmelstein J: *Reproductive hazards in the workplace: what the practitioner needs to know about chemical exposures.* Obstet Gynecol 1988; 71:921-938

**Paul ME**, Daniels C, Rosofsky R: *Corporate response to reproductive hazards in the workplace: results of the Family, Work, and Health Survey.* Am J Ind Med 1989; 16:267-280

**Paul ME**, Himmelstein J, Weinstein S, et al: *Ocular infections and the industrial use of microscopes.* J Occup Med 1989; 31:763-766

Daniels C, **Paul ME**, Rosofsky R: *Health, equity, and reproductive risks in the workplace.* J Public Health Policy, 1990; 11:449-462

Coghlin J, Gann P, Hammond K, Skipper P, Taghizadeh K, **Paul ME**, Tannenbaum S. *4-Aminobiphenyl hemoglobin adducts in fetuses exposed to the tobacco smoke carcinogen in utero.* J Natl Cancer Inst 1991; 83:274-280

**Paul ME.** *Physical agents in the workplace.* Sem Perinatol 1993; 17:5-17

Hammond SK, Coghlin P, Gann PH, **Paul M**, Taghizadeh K, Skipper PL, Tannenbaum SR. *The relationship between environmental tobacco smoke exposure and carcinogen- hemoglobin adduct levels in nonsmokers.* J Natl Cancer Inst 1993; 85: 474-478

**Paul ME**. Overview: *Conference on Occupational and Environmental Reproductive Hazards.* Environ Health Perspect; 1993; 101 (Suppl 2): 171-174

**Paul ME,** Welch L. *Improving education and resources for health and providers.* Environ Health Perspect, 1993; 101 (Suppl 2): 191-197

**Paul ME**, Kurtz S. *Analysis of reproductive health hazard information on material safety data sheets for lead and the ethylene glycol ethers.* Am J Ind Med 1994; 25:403-415

**Paul ME**. *Disorders of reproduction.* Primary Care 1994; 25:403-415

**Paul ME**. *A guest editorial: Reproductive hazards in the workplace.*. Obstet Gynecol Survey 1994; 49: 1-2

**Paul ME**, Hammond K, Abdollahzadeh S. *Power frequency magnetic field exposures in a neonatal intensive care nursery.* Bioelectromagnetics 1994; 15: 519-529

Kaczmarczyk JM, **Paul ME**. *Reproductive health hazards in the workplace: Guidelines for policy development and implementation.* Int J Occup Health 1996; 2: 48-58

**Paul ME**. *Occupational reproductive hazards.* Lancet 1997;349:1385-1388

**Paul ME**. *Office management of early induced abortion.* Clin Obstet and Gynecol, 1999; 42: 290-305

**Paul M**, Creinin MD (guest editors). Early medical abortion. Am J Obstet Gynecol Supplement, 2000, volume 183, number 2

**Paul M**, Schaff E, Nichols M. *The role of clinical assessment, human chorionic gonadotropin assays, and sonography in medical abortion practice.* Am J Obstet Gynecol, 2000; 183 (Suppl): S34-S43

Kruse B, Poppema S, Creinin MD, **Paul M**. *Management of side effects and complications in medical abortion.* Am J Obstet Gynecol, 2000; 183 (Suppl): S65-S75

Lichtenberg ES, **Paul M**, Jones H. *First trimester surgical abortion practices: a survey of National Abortion Federation members.* Contraception 2001;64:345-352

**Paul M**, Lackie E, Mitchell C, Rogers A, Fox M. *Is pathology examination useful after early surgical abortion?* Obstet Gynecol 2002;99:567-571; Also response to letter to the editor. Obstet Gynecol 2002;100:378-379

**Paul M**, Mitchell CM, Rogers AJ, Fox MC, Lackie EG. *Early surgical abortion: efficacy and safety.* Am J Obstet Gynecol 2002; 187:407-411

Sankey HZ, Lewis RS, O'Shea D, **Paul M**. *Enhancing resident training in abortion and contraception through hospital-community partnership.* Am J Obstet Gynecol 2003;189:644-646

**Paul M**, Nobel K. *Papaya: a simulation model for training in uterine aspiration.* Fam Med 2005;37:242-244

### *Other Publications*

Books

**Paul ME** (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, Inc. 1993

**Paul ME,** Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield P (eds). *A Clinician's Guide to Medical and Surgical Abortion.* New York: Churchill Livingstone, 1999

Book Chapters

Brent R, Meistrich M, **Paul M**. Ionizing and non-ionizing radiations. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, Inc., 1993

**Paul ME**. Video display terminals. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, Inc., 1993

**Paul ME**. Clinical evaluation and management. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, 1993

**Paul ME**. Common clinical encounters. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, 1993

**Paul ME**. Common home exposures. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, 1993

**Paul ME**. Polyhalogenated biphenyls. In: Paul ME (ed). *Occupational and Environmental Reproductive Hazards: A Guide for Clinicians.* Baltimore: Williams and Wilkins, 1993

**Paul ME**. Reproductive system disorders. In: Levy BS, Wegman B (eds): *Occupational Health: Recognizing and Preventing Work-Related Disorders*; 3rd ed. Boston: Little, Brown, and Company, 1996 (4th edition 2000)

Edwards J, Darney P, **Paul M.** Surgical abortion in the first trimester. In: Paul ME, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield P (eds). *A Clinician's Guide to Medical and Surgical Abortion.* New York: Churchill Livingstone, 1999

Randall L, **Paul M**, Herman S. Health and safety issues. In: Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield P (eds). *A Clinician's Guide to Medical and Surgical Abortion.* New York: Churchill Livingstone, 1999

Lichtenberg ES, Grimes DA, **Paul M**. Abortion complications: prevention and management. In: Paul M, Lichtenberg ES, Borgatta L, Grimes DA, Stubblefield P (eds). *A Clinician's Guide to Medical and Surgical Abortion.* New York: Churchill Livingstone, 1999

Fried M, **Paul M**. Abortion. In: Boston Women's Health Book Collective. *Our Bodies, Ourselves for the New Century*. New York: Simon and Schuster, 1998; revised edition 2004.

Monographs

**Paul ME**. Clinical risk assessment and management. In: Brenner D, Bloom A (eds.) *Assessing the Risks of Adverse Reproductive Outcomes. Monograph No. 4 of the Conte Institute for Environmental Health.* White Plains, NY: March of Dimes Birth Defects Foundation, 1990

Welch LS, **Paul ME** (guest editors): *Case Studies in Environmental Medicine: Reproductive and Developmental Hazards.* Atlanta: U.S. Department of Health and Human Services, Public Health Service, Agency for Toxic Substances and Disease Registry, September 1993

***Non-Peer Review Publications/Poster Presentations***

Daniels C, **Paul ME**, Rosofsky R. *Family, Work, and Health Survey Report.* Boston: Massachusetts Department of Public Health, 1988

**Paul ME**, Daniels C. *Health, equity, and reproductive risks in the workplace.* Second Annual Women's Policy Research Conference Proceedings. Washington, DC: Institute for Women's Policy Research, 1990

**Paul ME**, Kurtz S. *Reproductive Hazards in the Workplace: A Syllabus for Clinicians.* Worcester: University of Massachusetts Medical School, Occupational and Environmental Reproductive Hazards Center, 1990.

**Paul ME**. *Integration of occupational and environmental reproductive health issues into ob/gyn residency curricula.* Abstract and poster presentation, CREOG/APGO Annual Meeting, 1991

**Paul ME**, Kurtz S. *Analysis of reproductive health hazard information on material safety data sheets for lead and the ethylene glycol ethers.* Poster presentation, American Public Health Association Annual Meeting, 1992

**Paul ME**. *Reproductive hazards revisited.* Bulletin of the Society for Occupational and Environmental Health, 1993

**Paul M**, Nicholas C, Atkins R, Weiss J, Paul D. *Abortion Training: A Guide to Establishing an Effective Program at your Facility.* Worcester: Abortion Training and Advocacy Initiative, 1998

Goedken J, Poehlmann S, **Paul M**. *A blinded randomized clinical trial of misoprostol, dinoprostone, and oxytocin for labor induction.* Poster presentation. ACOG Annual Meeting, 2000

**Paul ME**, Mitchell C, Rogers A, Fox M, Lackie E. *Efficacy and safety of early surgical abortion.* Poster presentation. National Abortion Federation Annual Meeting, Chicago, 2001

**Paul ME**, Creinin MD (eds). *Early abortion options: a self-learning guide for health care professionals.* Washington DC: National Abortion Federation, 2001

**Paul M**, Stewart FH, Weitz TA, Wilcox N, Tracey JM. *Early Abortion Training Workbook.* San Francisco: UCSF Center for Reproductive Health Research and Policy, 2003.

Goodman S, Waxman NJ, Hammer H, Villela T, Nobel K, **Paul M**. *Training in Early Abortion for Comprehensive Healthcare (TEACH) with UCSF Family Medicine residencies.* UCSF Research Colloquium, October 29, 2004

## SUPPLEMENT FORM FOR LAPSED APPLICATION

PRINT NAME: MAUREEN ELIZABETH PAUL DATE: 04 / 19 / 2005

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

**QUESTIONS** **YES** **NO**

1-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?

1-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

2. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?

3-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

3-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association ( national, state or local)?

4-A. Have you ever voluntarily relinquished any medical staff membership?

4-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

4-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?

4-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

5. Have you ever been charged with any criminal offense, other than a minor traffic offense?

6. 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?

Signed: *Maureen Paul* Date: *04-19-2005*

| | | YES | NO |
|---|---|---|---|
| 7. | Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider? | | |
| 8. | Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs? | | |
| 9. | 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? | | |
| 10-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? | | |
| 10-B. | In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | | |

Applicant's Signature: *Maureen Paul* Date: *04/19/2005*

07/28/05 08 40

MALPRACTICE HISTORY

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

## MALPRACTICE HISTORY

<u>Applicant's Instructions:</u> 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. A copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History form(s) with your original signature to the Board of Registration in Medicine.**

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

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

**<u>Liability Carrier's Instructions:</u> If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.**

Liability Carrier: Univ. of Massachusetts Medical Center Self Insured Trust From: 01/87 To: ~~06~~ 05 (MP) /98
City: Worcester State: MA Policy Number: N/A

Liability Carrier: National Union Fire Ins. Co. ~~through Planned Parenthood Fed Am~~ From: ~~07/98~~ 12/97 (MP) To: 12/05
City: State: Policy Number: 6793286 (for 2005 - see attached for prior years) (MP)

Liability Carrier: American Home Assurance ~~through Planned Parenthood Fed Am~~ From: 12/94 To: 12/97
City: State: Policy Number: See attached } (MP)

Applicant's signature: Maureen Paul 05/18/05
Date

Print Name: MAUREEN PAUL
Address: Planned Parenthood Golden Gate - 815 Eddy St ~~(Suite 300)~~ City: San Francisco
State: CA. Zip code: 94109

**<u>Additional forms available at the Board's website at www.massmedboard.org</u>**

* Modified and initialed on 6/15/05, (M Paul)

# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul **License No.:** 48979

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/22/2006 **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.**

**Please make corrections (print)**

**2a) MAILING ADDRESS**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

RECEIVED
JUL 17 2006
Board of Registration in Medicine

☐ *Check here to change this address*

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**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

Phone:

☒ *Check here to change this address* (added phone only)

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (212) 274-7266

*Business address cannot be a Post Office Box*

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

**4) Fax Number:** 212-274-7276

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

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

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



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# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul  **License No.:** 48979

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

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

**9) What is your principal work setting?** *(See Renewal Instructions, page 4.)*
Principal Work Setting: Clinic  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* |
|---|---|---|---|---|
| Beth Israel Deaconess Medical Center | ☑ | | | |
| Clinic (Planned Parenthood League of MA) | ☐ | Active | | 3 |
| UMass Memorial Medical Center | ☑ | | | |
| Out of state hospital (Beth Israel NYC Med Ctr) | ☐ | Active | | 0 |
| Out of state clinic (Planned Parenthood of NYC) | ☐ | Active | | 40 |
| | ☐ | | | |
| | ☐ | | | |

**11) Care of patients in Massachusetts** *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 0 hrs/wk  Change to: ____ hrs/wk
b) outpatient care 21 hrs/wk  Change to: 3 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: National Union Fire Ins Co of Pittsburgh Change to: ____
Policy dates: From 12/31/05 To 12/31/06
*(required)*

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

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

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



07/18/06 S2

# Massachusetts Physician Renewal Application

**Physician Name: Maureen E Paul** **License No.: 48979**

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

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

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

| | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<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



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## Massachusetts Physician Renewal Application

**Physician Name: Maureen E Paul** **License No.: 48979**

### PHYSICIAN PROFILE

- [ ] I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- [x] 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: Maureen Paul Date: 07/17/06

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



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# Massachusetts Physician Renewal Application

**Physician Name: Maureen E Paul** **License No.: 48979**

07/18/06

## NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- ☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐
- ☐ I have personally applied for an NPI.
- ☐ 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: | 207V00000X | OBSTETRICS & GYNECOLOGY |
| Provider Taxonomy: | | |
| Provider Taxonomy: | | |

## NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): MA. Country of Birth (if outside the US): U.S.A.

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: Maureen Paul Date: 07/17/06

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

Mass.Gov

• online services • agencies • elected officials

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# Massachusetts Board of Registration in Medicine Physician Profile

07/21/2006 09:32

**MAUREEN E PAUL MD**

## I. Physician Information

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

| | |
|---|---|
| License Status: | Active |
| License Issue Date: | 03/02/1982 |
| Accepting New Patients: | No |
| Accepts Medicaid: | No |
| Primary Work Setting: | Clinic |
| Business Address: | Planned Parenthood NYC<br>26 Bleecker Street<br>NEW YORK, NY 10012 |
| Phone: | None Reported |
| Translation Services Available: | None Reported |
| Insurance Plans Accepted: | None Reported |
| Hospital Affiliations: | Clinic<br>~~Beth Israel Deaconess Medical Center~~<br>~~UMass Memorial Medical Center~~<br>*Beth Israel Medical Ctr. New York City, NY* (handwritten) |

## II. Education & Training

| | |
|---|---|
| Medical School: | Tufts University School of Medicine |
| Graduation Date: | 1979 |
| Post Graduate Training: | 7/1/1981-6/30/1984 - Tufts-New England Medical Cent - Resident: Obstetrics and Gynec<br>1/1/1987-12/31/1987 - Univ of MA Med Ctr - Resident: Occupational Medicin<br>9/1/1981-5/15/1987 - BU School of Public Health - |

## III. Specialty

| | |
|---|---|
| Area of Specialty: | Obstetrics and Gynecology<br>Occupational Medicine |
| ABMS Board Certification: | Obstetrics and Gynecology |

## IV. Honors and Awards

Distinguished Alumni Award Boston University

School of Public Health 2000
AMWA Reproductuve Health Award 1994

---

## V. Professional Publications

26 Articles and 2 Books in the area of reproductive Health.

---

## VI. Malpractice Information

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

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make Individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

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

**Dr. PAUL has not made a payment on a malpractice claim in Massachusetts in the last ten years.**

---

## VII. Disciplinary and/or Criminal Actions

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



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to supply this information to the Board.

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

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

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

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

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

---

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

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

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# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul **License No.:** 48979

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/22/2006 **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.**

**Please make corrections (print)**

**2a) MAILING ADDRESS**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

RECEIVED
JUL 17 2006
Board of Registration in Medicine

☐ *Check here to change this address*

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

**2b) HOME ADDRESS**

RECEIVED
JUL 27 2006
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**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

Phone:

☑ *Check here to change this address* (added phone only)

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (212) 274-7266

*Business address cannot be a Post Office Box*

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

**4) Fax Number:** 212-274-7276

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

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

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



007238962552

# Massachusetts Physician Renewal Application

Physician Name: Maureen E Paul

License No.: 48979

(See Renewal Instructions, page 4.)

**7) Drug License Numbers, if any:**

a) Massachusetts:

b) Federal (DEA):

c) Federal (DEA) XS:

*Please make corrections as necessary*

**8a) Other states where you are now licensed to practice (Abbr.)**

~~CT~~ NY, CA

**8b) States where you were previously licensed (Abbr.)**

WA CT

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

Principal Work Setting: Clinic 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* |
|---|---|---|---|---|
| Beth Israel Deaconess Medical Center | ☑ | | | |
| Clinic (Planned Parenthood League of MA) | ☐ | Active | | 3 |
| UMass Memorial Medical Center | ☑ | | | |
| Out of state hospital (Beth Israel Med Ctr NYC) | ☐ | Active | | 0 |
| Out of state clinic (Planned Parenthood of NYC) | ☐ | Active | | 40 |
| | ☐ | | | |
| | ☐ | | | |

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk

b) outpatient care 21 hrs/wk Change to: 3 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: National Union Fire Ins Co of Pittsburgh Change to: ______

Policy dates: From 12/31/05 To 12/31/06
*(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* ______



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# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul **License No.:** 48979

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.

| Question | 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



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# Massachusetts Physician Renewal Application

**Physician Name: Maureen E Paul** **License No.: 48979**

## 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: Maureen Paul Date: 07/17/06

**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: Maureen E Paul** **License No.: 48979**

0701820062S1

## NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- ☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐
- ☐ I have personally applied for an NPI.
- ☐ 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: | 207V00000X | OBSTETRICS & GYNECOLOGY |
| Provider Taxonomy: | | |
| Provider Taxonomy: | | |

## NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): MA. Country of Birth (if outside the US): U.S.A.

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: Maureen Paul Date: 07/17/06

**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:** Maureen E Paul, M.D. **License No.:** 48979

08/26/08 S1 14

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/22/2008 **Birth Date:**

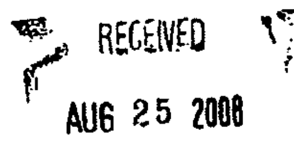
If you want to change your current status, please check *one* of the following boxes to indicate your *new* status:

**Check only one:** (*See Renewal Instructions, page* 3.)

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

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

**2a) MAILING ADDRESS**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012




☐ *Check here to change this address*

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

**2c) BUSINESS ADDRESS**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

Phone: (212)274-7266

☐ *Check here to change this address*

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

**4) Fax Number:** 212-274-7276

**Please make corrections (print)**

Mailing Address: ______________
City/Town: ______________ State: ______
Zip: ________ Country: ______________

Home Address: ______________
City/Town: ______________ State: ______
Zip: ________ Country: ______________
Home Telephone: (___)__________

*Home address cannot be a Post Office Box*

Business Address: ______________
City/Town: ______________ State: ______
Zip: ________ Country: ______________
Business Telephone: (___)__________

*Business address cannot be a Post Office Box*

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

______________

______________

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

# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

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*(See Renewal Instructions, page 4.)*

**7) Drug License Numbers** **Corrections:**

a) Massachusetts: ______

b) Federal (DEA): ______

c) Federal (DEA) XS: ______

*Please make corrections as necessary*

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

NY CA

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

WA CT AR

**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? |
|---|---|---|---|
| Clinic (Planned Parenthood League of MA.) | Boston, Worcester, Springfield | MA | ☐ |
| Out of State Hospital (Beth Israel Medical Center) | New York | NY | ☐ |
| | | | ☐ |
| Out of state clinic (Planned | | | ☐ |
| Parenthood of NYC) | New York | NY | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk

b) outpatient care 3 hrs/wk Change to: 6 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: National Union Fire Ins Co of Pittsburgh Change to: ______

Policy dates: From 01/01/08 To 01/01/09

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: Maureen E Paul, M.D.** **License No.: 48979**

06/26/08 S1

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

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

| Question | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<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: Maureen E Paul, M.D.** **License No.: 48979**

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## 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: Maureen Paul MD Date: 08 / 12 / 2008

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

# Massachusetts Physician Renewal Application

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/22/2008 **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**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

☐ *Check here to change this address*

RECEIVED
AUG 25 2008
Board of Registration in Medicine

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**
Planned Parenthood NYC
26 Bleecker Street
New York, NY 10012

Phone: (212)274-7266

☐ *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:** 212-274-7276

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

____

____

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

MASSACHUSETTS PHYSICIAN RENEWAL APPLICATION

Maureen Paul MD License Number 48979

11. Care of patients in Massachusetts Continued:

I reside in New York where I hold a fulltime position as Chief Medical Officer of Planned Parenthood of New York City. However, I also work part-time providing per diem clinical services at Planned Parenthood League of Massachusetts (PPLM), typically 3-4 days per month. I work as needed at any of the three PPLM clinics located in Springfield, Worcester or Boston.

Maureen Paul 09/02/2008

# Massachusetts Physician Renewal Application

Physician Name: Maureen E Paul, M.D. License No.: 48979

*(See Renewal Instructions, page 4.)*

7) Drug License Numbers — Corrections:

a) Massachusetts: ____
b) Federal (DEA): ____
c) Federal (DEA) XS: ____

*Please make corrections as necessary*

8) Other states where you are now licensed to practice

NY CA

9) States where you were previously licensed

WA CT AR

**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? |
|---|---|---|---|
| Clinic (Planned Parenthood League of MA.) | Boston, Worcester, Springfield | MA | ☐ |
| Out of State Hospital (Beth Israel Medical Center) | New York | NY | ☐ |
| | | | ☐ |
| | | | ☐ |
| Out of state clinic (Planned Parenthood of NYC) | New York | NY | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk
b) outpatient care 3 hrs/wk Change to: 6 hrs/wk

See attached sheet 9/2/08 MP

**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: National Union Fire Ins Co of Pittsburgh Change to: ____

Policy dates: From 01/01/08 To 01/01/09

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)*: ____

9/2/08 MP

**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:** Maureen E Paul, M.D. **License No.:** 48979

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08/26/08 S1
4
15

*(See Renewal Instructions, page 4.)*

**7) Drug License Numbers** **Corrections:**

a) Massachusetts: ______
b) Federal (DEA): ______
c) Federal (DEA) XS: ______

*Please make corrections as necessary*

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

**9) States where you were previously licensed**
WA CT AR

**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? |
|---|---|---|---|
| Clinic (Planned Parenthood League of MA.) | Boston, Worcester, Springfield | MA | ☐ |
| Out of State Hospital (Beth Israel Medical Center) | New York | NY | ☐ |
| | | | ☐ |
| Out of state clinic (Planned Parenthood of NYC) | New York | NY | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ______ hrs/wk
b) outpatient care 3 hrs/wk Change to: 6 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: National Union Fire Ins Co of Pittsburgh Change to: ______

Policy dates: From 01/01/08 To 01/01/09

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:** Maureen E Paul, M.D. **License No.:** 48979

08/03/08 S3
08/26/08 S1

**In questions 14-21, the phrase "time period" refers to the following – all time from the day you signed your last license Renewal Application to the day you sign this Renewal Application.** *(See Renewal Instructions, page 5.)*
You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

| Question | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<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: Maureen E Paul, M.D.** **License No.: 48979**

09/02/08 08/26/08 15 23 7 18

## 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: Maureen Paul MD Date: 08/12/2008

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

**Current Status:** Active **License Expiration Date:** 9/19/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

Planned Parenthood NYC
26 Bleecker Street
New York
New York - 10012
United States of America

**Home Address:**

**Business Address:**

Planned Parenthood NYC
26 Bleecker Street
New York
New York - 10012
United States of America
(212) 274-7266

3) **Email Address:**

4) **Fax Number:** (212) 274-7218

5) **Specialties**
Gynecology
Occupational Medicine

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 | |
| ABMS | Preventive Medicine | Occupational Medicine | |

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
California
New York

9) **States where you were previously licensed**
Connecticut
Washington

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

**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 |
|---|---|
| Out of State Hospital | NYC |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 8 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| National Union Fire Ins Co of Pittsburgh | 01/01/2010 | 01/01/2011 | Claims made with tail coverage |

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

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

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

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

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

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

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?

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

## 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:** Maureen E Paul, M.D. **License No.:** 48979

**Current Status:** Active **License Expiration Date:** 9/19/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**
Planned Parenthood League of Massachusetts
1055 Commonwealth Av
Boston
Massachusetts - 02215
United States of America

**Home Address:**

**Business Address:**
Planned Parenthood League of Massachusetts
1055 Commonwealth Av
Boston
Massachusetts - 02215
United States of America
(617) 616-1600

3) **Email Address:**

4) **Fax Number:** (617) 616-1675

5) **Specialties**
Obstetrics and Gynecology
Occupational Medicine

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 | |
| ABMS | Preventive Medicine | Occupational Medicine | |

7) **Drug License Numbers**

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

8) **Other states where you are now licensed to practice**
Maine
New York

9) **States where you were previously licensed**
California
Connecticut
Washington

**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 |
|---|---|

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:**
**a) inpatient care** 0 hrs/wk
**b) outpatient care** 15 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| National Union Fire Ins Co of Pittsburgh | 01/01/2012 | 01/01/2013 | Claims made with tail coverage |

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

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

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

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

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

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

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

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

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

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

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

## 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.

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

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

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

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

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

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

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

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

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

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

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

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

**Current Status:** Active **License Expiration Date:** 9/19/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

BIDMC Dept OB-Gyn, KS-3
330 Brookline Av
Boston
Massachusetts - 02215
United States of America

**Home Address:**

**Business Address:**

BIDMC Dept OB-Gyn, KS-3
330 Brookline Av
Boston
Massachusetts - 02215
United States of America
(617) 667-4165

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology
Occupational Medicine

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

| ABMS/AOA | Board Name | Certification | Subspecialty |
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7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
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8) **Other states where you are now licensed to practice**
Maine
New York

9) **States where you were previously licensed**
California
Connecticut
Washington

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

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

| WorkSite | Location |
|---|---|
| Beth Israel Deaconess Medical Center | Boston |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 15 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
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| CRICO | 01/01/2014 | 12/31/2014 | Claims made with tail coverage |
| National Union Fire Ins Co of Pittsburgh | 01/01/2014 | 01/01/2015 | Claims made with tail coverage |

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

**14) Claims Made**
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d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

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?**

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

**Physician Name:** Maureen E Paul, M.D. **License No.:** 48979

## 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.

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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.

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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.

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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.

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[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.**