

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, <u>please read the instruction booklet</u>. 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 <u>green</u> envelope <u>4 weeks</u> 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.

1. Current Status:	Active	Registration N	No.:47131	Renewal Date: 01/08/2001
If you want to change	your current status, p	lease check one	e of the fol	lowing boxes to indicate your <u>new</u> status: (Check only one)
Active	Retiring (see instru	ctions)	Inactiv	e (see instructions) Do not wish to renew
2. Other Name(s), if a	any, under which you	were licensed:		Please make corrections (type or print)
		الصين		Other Name(s):
3. A) Mailing/Busin Ellen M Penso 58 Day Street,		[[[] [] [] [] [] [] [] [] []		Mailing Address: City/Town: State:
Somerville, M	A 02144-2800 (E)	DEC 2 67	\	Zip: Country:
B) Home Address	S. REGIONS	888	3 3	Business Address: City/Town: State: Zip: Country:
				Business Telephone: () Home Address:
Home Phone:		·		City/Town: State: Zip: Country: Home Telephone: ()
Business Phone:	(617)628-3710		ı	PLEASE NOTE: No P.O. Box addresses for home or business addresses.
4. a) Date of Birth:	b) Sex:	F		ent American Board of Medical Specialties Certification (See Table 2 Gode: Code:
c) SS#:		*	8. Dru	g License Numbers, if any:
5. a) Name of Medical	School:		a) l	Federal (DEA): Massachusetts:
University of M b) Year Graduated:	liami School of Medic 1977 c) Degr	ine ee: M.D.	,	Other states where you are now licensed to practice (Abbr.)
6. Specialty Code(s) (Seconde(s) Hours	per Week in Mass.	_	b) S	tates where you were previously licensed (Abbr.)
GYN 0 0	Gynecology 6	O Hns		
the codes from Tab	<u>le 3</u> and place a check	mark next to th	iose health	ntialing process for the provision of patient care. (Supply care facilities where you have admitting privileges (AP). re hours that you provide in each facility).
Facility Code: 75/ Facility Code: 7// If 999, print name(s):	V (AP) /00 % Fa	cility Code:	299/	(AP) <u>O</u> % Facility Code:/(AP)% (AP)% Facility Code:/(AP)%

P	RINT YOUR LAST NAME: PENSO LICENSE NUMBER: 4	7131	
		<u> </u>	
11	. My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit Name of Insurer:	•	•
Ιá	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 b) Otherwise exempt		
Pl	ease explain exemption:		
12	. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check or	ne) Yes	TV No
	. A. What is your principal work setting? (See Table 4)	, 🗀	22 - 10
	B. Care of patients in Massachusetts (see instruction booklet).		
	1) Average weekly hours involved in: a) outpatient care 59 hrs/wk b) inpatient care 6 hrs	/wk	
	2) What is the approximate percentage of your patient care hours in primary care? 95 %		
PA	ART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
Qu det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each que tails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in finitions. You must answer ALL questions, or this form will be returned to you and your license renewal man	nformation	and
		YES	NO
14.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally	IES	WO.
	settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15.	<u>CLAIMS RESOLVED:</u> 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?		1
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?		i
20.	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		-
	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?	Planting Angle Marting States discovers and	, T. C.
22.	CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? Ye	s 🔲 1	Nο
	CME Waiver requested (CME waiver form due 30 days prior to date of license expiration)	ME exempti	ion
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applic		
	suant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fce schedule		
Purs Mas	suant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and p sachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you reside out-of-state or out of the Unit	aid all led 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 withholding and remitting Child Support.	relating to	
•	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		
	57		
Sign	nature:Date: 12	12210	0

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.



5.

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

Before proceeding, please read the instruction need copies for credentialing and other purpose green envelope at least 4 weeks before your ren	n hooket. Cons	this former	del att	achments for attachments	your own must be re	<u>records;</u> y eturned in	ou will the
•Remit \$400.00 for renewal fee (non-refu •Add late fee of \$25.00, if necessary.	ndabe). BOARD OF R	Reti	rn renew	al applicatio	n in GREE	N envelor	oe.
Please review carefully the following in alterations as required. All questions m	nformation for					correcti	ions or
1. Current Status: Active Regis	stration No.:47131		Re	newal Date: 0	1/08/2003		
If you want to change your current status, please of	heck <u>one</u> of the fol	llowing boxe	s to indic	ate your new	status: (Che	ck only o	ne)
☐ Active ☐ Retiring (see instructions)	☐ Inacti	ve (see instr	uctions)	□ Do	not wish to	renew	
2. Other Name(s), if any, under which you were li	censed:	Please mal	ke correc	tions (print)			
A) Mailing/Business Address: 3. Ellen M Penso 58 Day Street, Suite 229			ame(s)		Change (ent		elow)
Somerville, MA 02144-2800		City/Town:	iress:			State:	
B) Home Address:		Zip:		Country:			
		Zip:		Country:		State:	
Home Phone: Business Phone: (617)628-3710		City/Town: _ Zip: Home Telepi PLEASE No	hone: OTE: O	Country: () nly one addre	ess can be a		
a) Date of Birth: b) Sex:				dical Specialt		tion (See "	Poblo 2)
c) SS#:	Code:		Code	•	ies Cei illica	.non (Sec <u>1</u>	(ADIC 2)
a) Name of Medical School:	a) Feder	nse Numbers al (DEA):	, if any:				
University of Miami School of Medicine 1977 c) Degree M.D.		achusetts: r states wher	e you are	now licensed	to practice	(Abbr.)	
pecialty Code(s) (See <u>Table 1</u>) ode(s) Hours per Week in Mass.	b) State	s where you	were prev	viously license	ed (Abbr.)		
GYN 0 Gynecology					-		
O. List all current health care facilities at which you are. (Supply the codes from <u>Table 3</u> and place a chext to each facility, write the approximate percentage	neck mark next to t	hose health c	are facili	ties where you	ı have admi	tting privi	ges (AP)
acility Code: 751 (AP) 100 % Facility acility Code: (AP) % Facility 999, print name(s):	Code:/_	(AP)	_% Facil _% Facil	ity Code:		AP) AP)	_% %

PRI	INT YOUR LAST NAME:	PENSO	1	LICENSE NUMBER:	47121		<u> </u>
11.	My medical malpractice insura	ance is covered by Insuranc					<i>j</i> ~
	Insurer's name. (Required):_	PROMUTUM	Policy dates	: From: 6/30/0	2To: 6	130/03	<u> </u>
		ws: I am registering with Active Not involved in direct/indirect					
	Otherwise exempt Please e	xplain exemption:			····		
	What is your principal work se for the provision of patient car	etting? (See <u>Table 4</u>)		iliated with a healthcare ist your affiliations.	facility or	credentia	led
13.	Care of patients in Massachuse		1		•		
	1) Average weekly hours	involved in: A) inpatient care	hrs/wk	B) outpatient care 54	_hrs/wk		
	2) What is the approximat	e percentage of your patient care	hours in primary	care? <u>95</u> %			
PA	RT A - QUESTIONS RI	EFER ONLY TO THE PA	ST TWO (2)	YEARS (SEE INS	TRUCTI	ONS)	
ques	stion. Provide details on For	the period since you signed you m R for all YES answers (except this section must be answered	t question 22). I	Refer to instructions fo	r addicions	Linform	ation
					1	YES	NO
14.	CLAIMS MADE (New or Pe	nding): Has any medical malpra	actice claim been	made against you that h	as not	, <u>1.4;</u> ×	*****
	yet been finally settled or adju-	licated, whether or not a lawsuit	was filed in relati	on to the claim?			
		ny medical malpractice claim tha ved, whether or not a lawsuit was			'		1
16.	Has any lawsuit, other than a n	nedical malpractice suit, which is	related to your co	ompetency to practice m			
	or your professional conduct in otherwise resolved?	the practice of medicine, been fi	iled against you o	r been settled, adjudicat	ed or		
	Have you been charged with a	iv criminal offense?					
18.	Have you been charged with or	disciplined for any violation of alth care facility, group practice			ce of		
	Has your privilege to possess, crestricted by, or surrendered to	dispense or prescribe controlled s any state or federal agency?	substances been su	uspended, revoked, deni	ed,		
20 .]	Have you withdrawn an applica	ation for a medical license or bee	n denied a medica	al license for any reason	?		
	co-payment, or placed any con-	nsurance provider restricted, limi dition related to professional comed or terminated your insurance of provider?	petency or condu	ct on your coverage, or	have		
22. 9	CME CERTIFICATION: He	ive you completed your CME rec	quirements preced	ling your renewal date?	Yes	☐ No	
ł	CME Waiver. CME waive	er form must be submitted at leas	t 30 days prior to	license expiration date.			
9	CME EXEMPTION: Check	one: Inactive status	Residency/Fel	lowship training (See in	structions).		
		lver or exemptions. Do not sub					
•	and the punishment for fail		-	_		·	
•	amount.	c. 2, I will not charge to or collec	ct from a Medicar	e beneticiary more than	the Medica	ie iee sci	iedul
•	Massachusetts state tax retu	A, I certify that I have complied arms and payment of all Massaching and remitting child support pu	usetts state taxes;	reporting of employees	and contrac	ing of ctors t de	r
I he	ereby certify under the penal	ties of perjury that all informat	ion on this Rene	wal Application, Part	B and Forn	nR str	ue.
Signa	iture:	Clikens	LOUD	Da	nte: <u>//</u> /	110	22
		AND INCLUDE PART B.					
		require that you notify the					

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

F.H.

Massachusetts Physician Renewal Application

Physician Name: Ellen M Penso License No.: 47131 PART A 1) Current Status: | Active Due Date: 12/09/2004 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 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. Piease make corrections (print) 2a) MAILING ADDRESS 58 Day Street, Suite 229 Mailing Address: Somerville, MA 02144-2800 City/Town: ____ _ Country: ___ Check here to change this address **2b) HOME ADDRESS** Address: Registration in ____ State:____ Country: Home Telephone: (Phone: Home address cannot be a Post Office Box Check here to change this address 2c) BUSINESS ADDRESS Business Address: 58 Day Street, Suite 229 Somerville, MA 02144-2800 City/Town: State: Zip; Country: Business Telephone: (Phone: (617)628-3710 Business address cannot be a Post Office Box Check here to change this address 3) E-mail Address: (617)629-2452 4) Fax Number:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Gynecology		
6) Current American Board of Medical Specialties American Osteopathic Association (AOA) Certific Renewal Instructions, page 4.)	s (ABMS) or cations. (See Delete?	Additional certifications:
Obstetrics & Gynecology	n	
Neurology	1993	

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Massachusetts Physician Renewal Application Physician Name: Ellen M Penso License No.: 471

(See Renewal Instructions, page 4.) 7) Drug License Numbers, if any: a) Massachusetts: b) Federal (DEA): c) Federal (DEA) XS:	8a) Other	states w		ary ow licensed to pra				
Principal Work Setting: Private Office	9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Private Office Change to: Hours per Week: 54							
10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.								
No Affiliations								
Health Care Facility (See Renewal Instructions, page 4	1.)	Delete?	Staff (Current	Category Change	# Hours per Week			
Cambridge Hospital (The)		X			-			
Mount Auburn Hospital		[2]						
New England Medical Center Hospitals		X						
Newton-Wellesley Hospital			Acrive		6			
Quincy Hospital		X						
11) Care of patients in Massachusetts (See Renewal In:	structions n	noe 4)						
Average weekly hours involved in: a) inpatient care	6_ hr		Change to:	hrs/wk				
b) outpatient care			Change to:					
12) Medical Liability Insurance Information (See Rend		tions, pa	ge 5.)					
My medical liability insurance is provided through: (check one)				·			
Insurance Carrier (complete below)								
Current Insurance Carrier: ProMutual Group		Cl	nange to:					
Policy dates: From 6/30/04 To 6 (required)	130/0	05						
Letter of Credit subject to Board approval (atta-	ch a copy)							
☐ I am registering with Active status but I am not	t required to	o have m	edical liability	insurance because	· I am:			
Check one: Not involved with direct or i Government Employee Fede Otherwise exempt (Please ex	indirect patie	ent care in ims Act (n Massachusetts	3	43 222 3			

Physician Name: Ellen M Penso	License No.:	47131
Do you perform any surgery in your office? (See Renewal Instructions, page 5.) If Yes, please complete Form PCA-O "Office Based Surgery"	Yes	No

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

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

_		YES	NO	
	 14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? 		-	
	b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?			
	15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		***************************************	
	16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.			
	a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?			
1	b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?			
-	17) CRIMINAL CHARGES			
	a) Have you been charged with any criminal offense during this time period?	: [
	b) Are there any criminal charges pending against you today?			
	c) Have any criminal offenses/charges against you been resolved during this time period?			
	18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?			
	19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?			
2	O) 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?			
2	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?			
	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.)		ſ	
	CME EXEMPTION: (check onc)			

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Massachusetts Physician Renewal Application

Physician Name: Ellen M Penso License No.: 47131

PHYSICIAN PROFILE	
I have reviewed my Physician Profile at <u>profiles.massmedboard.org</u> 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. 5 and I understand the punishment for failure to comply.	JA
2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19 sec. 10, and I understand the punishment for failure to comply.	C,
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. 12.	to
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.	0
6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 1 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.	12,
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.	
B) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and inderstand 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.	J
e) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.	J,
(0) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to 3.L, c. 119A.)
1) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse even 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 Catassessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.	ts are
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 is Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.	in
Signature;	

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

N	1

NATIONAL PROVIDER IDENTIFIER (NPI) REPORTING FORM

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.

programs and health care purchasers for purposes of conducting these business transactions.	
Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.	
Please select one option below:	
Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov. . Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org . Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (suppled institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2). Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf. Check the appropriate box below, supply appropriate information, and sign the bottom of the page. My current NPI is: I have personally applied for an NPI. I have applied for an NPI using a third party (enter name):	Ξ .0
By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.	
HIPAA TAXONOMY CODES Please provide the HIPAA taxonomy (specialty) codes (refer to the Taxonomy Codes and Additional NPI Information at the Board's website for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxono Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.	my
Taxonomy (Specialty) Code Taxonomy Description (Print)	
Primary Provider Taxonomy: 207VG0900X 0BSHETRICS of GANRICOLOGY-	<u>u</u> llo
NPI REQUIRED INFORMATION	-
In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections an eccessary. Please note: This information is required if you authorize BORIM to apply for an NPI on your behalf.	15
Social Security Number:	
State of Birth (if US): Country of Birth (if outside the US):	
Gender: Male Female	
Penalties for Falsifying Information on the National Provider Identifier Application 8 U.S.C. 1001 suthorizes criminal penalties against an individual who in any matter within the jurisdiction of any denoting the support 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:

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

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(V) (V)

Massachusetts Physician Renewal Application

Physician Name: Ellen M Penso, M.D. License No.: 47131 PART A 1) Current Status: Active Renewal Due Date: 12/11/2006 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.) ☐ 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 241 Boston Post Road NOV 16 2006 Mailing Address: City/Town: State: Wayland, MA 01778 Board of Registration Zip: Country: in Medicine Check here to change this address **2b) HOME ADDRESS** Home Address: Zip: Country: Home Telephone: (____) Phone: Home address cannot be a Post Office Box Check here to change this address 2c) BUSINESS ADDRESS Business Address: 241 Boston Post Road 3 A Zip: Country: Wayland, MA 01778 Business Telephone: (____)____ Phone: (508)358-5707 Business address cannot be a Post Office Box Check here to change this address Correct your E-mail and Fax Number below: 3) E-mail Address: 4) Fax Number: 508-358-5709 5) Specialties (See Renewal Instructions, page 4.) Delete? List Additional Specialties: Gynecology 6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. (See enclosed instructions and Renewal Instructions, page 4.) Update General Certificates and Subspecialty Certificates List Certifying Board(s) below: below. Please add additional Certifications as required. Certificate/Subspecialty Board Name ABMS or AOA Delete? Obstetrics and Gynecology Obstetrics & Gynecology **ABMS**

11/11/19 01

3)

. Massachusetts Physician Renewal Application
Physician Name: Ellen M Penso, M.D.

License No.: 47131

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

10) List all work sites in Massachusetts, includir offices, clinics, nursing homes, etc. For the name page 18 of the Renewal Instruction booklet. Incor companies. Please provide all information on	es of the health care facilities, refer to clude any affiliations with Internet-ba a all work sites, attaching a separate s	Reference Ta sed prescribin	ble 4 on g services
List the names of all work sites in Massachusetts (See above and description on page 4.)	Location (City or Town)	State	Delete?
Newton-Wellesley Hospital	Newton	MA	
Average weekly hours involved in: a) inpatient care b) outpatient care b) outpatient care check one. Locum tenens must list policy dates. My Insurance Carrier (complete below) Current Insurance Carrier: ProMutual Group Policy dates: From 6/30/06 To Type of Policy: Claims made with tail cov Letter of Credit subject to Board approval (An	change to: 40 10 10 10 10 10 10 10	hrs/wk	
l am registering with Active status but I am no		ансе ресицье і 2	1411.
	r indirect patient care in Massachusetts under Federal Tort Claims Act (FTCA)		
-			
U Otherwise exempt (Please	explain):		
13) Do you perform any surgery in your Massachuse If Yes, please complete Form PCA-O "Office B		? 5.) Yes	No

Physician Name: Ellen M Penso, M.D. License No.: 47131

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

YES NO

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

Physician Name: Ellen M Penso, M.D. License No.: 47131

PART C

Check	One: PHYSICIAN PROFILE	ς 4
-	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.

		<u>`</u>	, , , , , , , , , , , , , , , , , , ,					
Signature:			Levisous	Date:	- 11	/	10	16
•	7			-				

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.

Mass	achusetts Physician R	enewal Application	4ee J.,
Physician Name: Ellen M	Penso, M.D.	License No.: 47131	
and health care purchasers for purp	tifiers assigned to health care provider poses of conducting these business tran	ers as "health care providers" in HIPAA standards, such as those assigned by health plans, govern	ment programs
Option 1: Supply the Board of Resite at www.NPPES.cms Option 2: Certify you have person you must notify the Board Option 3: Certify another authorize institution's name). Once Board's website (see Option 4: Authorize the Board of Residue).	s.hhs.gov. ally applied for your NPI and you have rd. Please complete the NPI form at the red institution has applied for an NPI of e you have received your NPI Number, tion 2). Registration in Medicine to apply for an	NPI. You can apply for an NPI directly by using a not received it yet. Once you have received you a Board's web site at www.massmedboard.org , in your behalf and you have not received it yet (so you must notify the Board by completing the Nima NPI on your behalf.	ur NPI Number,
Check the appropriate box below, s My current NPI is: I have personally applied for	NACTIVE, you may elect not to obtain supply appropriate information, and sign of the second supply an NPI. (You must provide your NPI)	n the bottom of the page.	
		(follow instructions fo	•
		y authorize the Board to apply for an NPI on my	behalf.
☐ As an <i>inactive</i> physician, I do	not wish to obtain an NPI.		
providing the taxonomy code, pleas	HIPAA TAXONOMY CODE by (specialty) codes (refer to Renewal late indicate your specialty in the space pathorize BORIM to apply for an NPI of	Instructions, page 21 for more information). In according (Taxonomy Description). The primary representation of the primary re	ddition to provider
	· Taxonomy (Specialty) Code	Taxonomy Description (Print	Ď.
Primary Provider Taxonomy:	207 VG 040	OX OBSTETRICS . Gynecold	96v-lanvocala
Provider Taxonomy: Provider Taxonomy:			
•	NPI REQUIRED INFORMATION	ON	PA
In an ongoing effort to improve the as necessary. Please note: This info	quality of the information we collect,	Dease review the following information and make ORIM to apply for an NPI on your behalf.	e corrections
Social Security Number:			
State of Birth (if US):	FLA. Country of Bi	rth (if outside the US):	
Gender: Male	☑ Female		
Penalties f	or Falsifying Information on the Nat	ional Provider Identifier Application	
18 U.S.C. 1001 authorizes criminal the United States knowingly and wil fictitious or fraudulent statements or fictitious or fraudulent statement or Offenders that are organizations are	penalties against an individual who in Ifully falsifies, conceals or covers up by representations, or makes any false wi entry. Individual offenders are subject	any matter within the jurisdiction of any departm y any trick, scheme or device a material fact, or riting or document knowing the same to contain a to fines of up to \$250,000 and imprisonment for U.S.C. 3571(d) also authorizes fines of up to twi-	makes any false. any false, up to five years
authorize the Roard of Degistrati-	Authorization for NPI I	Dissemination	AL
Signature:		any authorized hospital, health plan, or health	in organization
		MENTS BEFORE MAILING. YOU MUST R	TOTAL A
COPY OF YOUR APPLICATION	ON FOR YOUR RECORDS, FOR	CREDENTIALING AND OTHER PURPOSE	eiaina Es.

Page 7 of 9

Physician Name: Ellen M Penso, M.D. License No.: 47131

PART A				
1) Current Status: Active	Renewal Due Date	e: 12/11/2008	Birth Date:	
If you want to change your current s	tatus, please check g	ne of the following bo	exes to indicate your <u>new</u>	z status:
Check only one: (See Renewal Ins			-	
☐ Active ☐ Retiring	□ Ina	ctive	Do not wish to renev	V
2) Addresses & Contact Information. Please required to notify the Board of Registration Business addresses CANNOT be a Post Office.	n in Medicine with	in 30 days of any cha	nge of address. Home	are
2a) MAILING ADDRESS		Please make cor	rections (print)	İ
241 Boston Post Road		Mailing Address		
3 A				
Wayland, MA 01778		City/Town:	Sta	ite:
Check here to change this address		Zip:	Country:	
2b) HOME ADDRESS				
		Home Address:		
And The Local	Section of the sectio	City/Town:	S	tate:
	4	Zip:	Country:	
Phone: NOV 1 (2008	Home Telephone: ()	
Phone: NUV I C			cannot be a Post Office	**
2c) BUSINESS ADDRESS in Med	icine	Business Address:		
241 Boston Post Road 3 A				toto.
Wayland, MA 01778			S	
•			Country:	
Phone: (508)358-5707	l		: ()	
Check here to change this address	1		ress cannot be a Post Of	
3) E-mail Address:		Correct your E-m	ail and Fax Number be	low:
4) Fax Number: 508-358-5709				
5) Specialties (See Renewal Instructions, page	ge 4.) Delete?	List Additiona	l Specialties:	
Gynecology				
6) Current American Board of Medical Sp (See enclosed instructions and Renewal Instru	pecialties (ABMS) of ructions, page 4.)	r American Osteopa	thic Association (AOA)	Information.
List Certifying Board(s) below:	Update General	Certificates and Subs I additional Certifica		
Board Name ABMS or AOA	l		orress sur a triple tus	Dalassa
Obstetrics & Gynecology ABMS	Obstetrics and Gyr			Delete?
гимо с супосою ду	Societies and Gy		""	
			,	

Physician Name: Ellen M Penso, M.D. License No.: 47131 (See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers Corrections: 8) Other states where you are now licensed to practice a) Massachusetts: b) Federal (DEA): 9) States where you were previously licensed c) Federal (DEA) XS: 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 Location State Delete? (See above and description on page 4.) (City or Town) Newton-Wellesley Hospital MA Newton 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 40 hrs/wk b) outpatient care Change to: hrs/wk 12) Medical Liability Insurance Information (See Renewal Instructions, page 5.) Check one. Locum tenens must list policy dates. My medical liability insurance is provided through: Insurance Carrier (complete below) Current Insurance Carrier: ProMutual Group Change to: _ From 6/30/2005 Policy dates: To 6/30/2009 ☐ Claims made with tail coverage Type of Policy: 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.

Physician Name: Ellen M Penso, M.D. License No.: 47131

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

YES NO 14) CLAIMS MADE a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above). b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated? 15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period? 16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? 17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you? 18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? 22) CME CERTIFICATION: a) Have you completed your CME requirements preceding your renewal date? b) If no, are you requesting a CME waiver? 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

Physician Name: Ellen M Penso, M.D. License No.: 47131

<u>P</u>	ART	· C	φ Θ Θ
	Chec	FRISICIAN PROFILE	
	K	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.)	(P) (pi
		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.)	
		<u>CERTIFICATIONS</u>	
	1) I co under	ertify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I retand the punishment for failure to comply.	
	2) I co I undo	ertify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, erstand the punishment for failure to comply.	, and
1	3) I co G.L. o	ertify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to c.19A, sec. 15, and I understand the punishment for failure to comply.	
	4) I ce sec. 1	ertify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 12A.	112,
:	5) I ce sec. 1:	ertify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 1 2A 1/2.	12,
,	5) I ce when	ertify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.	,
1	7) I ce with tl	ertify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.	ice
t	3) I ce hat, p erjur	ertify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understate oursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of y.	ınd of
ç) I ce	ertify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.	
1	0) I c	certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.11	9A.
F	rivate	certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in a 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 tient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board	
l	2) I c egal e	sertify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.	r
ii h u ii li	nstru ereii ndei nfori	r penalties of perjury, I declare that I have examined this renewal application and all its accompanying actions, forms and statements, and to the best of my knowledge and belief, the information contained in is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I restand that a criminal record check may be conducted for conviction and pending criminal case mation from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessarily disqualify me from the Criminal History Systems Board only and that it will not necessar	

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.

IOARD OF REGISTRATION IN MEDICINE ROOM 1507 -- 100 CAMBRIDGE STREET BOSTON, MASSACHUSETTS 02202 RENEWAL APPLICATION 1986-1988

LICENSE NUMBER

ELLEN M PENSO

HEGISTRATION NO.

47131

IMPORTANT -- READ, COMPLETE AND SIGN --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

SOC SEC NO. OPTIONAL YOU MUST SIGN BELOW

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS
ON THE REVERSE SIDE OF THIS APPLICATION. (SEE
THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO ANY OF THESE QUES-
TIONS, YOU MUST CHECK THIS BOX:

APPERCANTE SUPLIABILITY					PLEASEUS	SE THE ENCLOSED RETURN ENVELOPE	
PAY THIS AMOUNT	FEE	MO.			LATE FEE	NOTE!	THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A \$100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS
100.00	100.00	01	15	86			PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DU NUT WHITE BELOW THIS LINE

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:

P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

COMMONWEALTH OF MASSACHUSETTS

SEE REVERSE SIDE

MD DO NOT FOLD OR STAPLE THIS FORM

CODE

TYPE

3500600471318 011586 10000000004

Print Name: ELENTENSO	Date of Birth:	
Medical School: UNIV. of MIAMI School of ACAKINCOate of Gra	duation 6 5 1 9 7 7	
You must read the instructions enclosed with this form to answer questions 1-12.	ARUL - ACCION	
1. Principal Specialty(ies): 08/6-y/	2. Principal work setting: PRIVATE OFFICE.	
3. Home address:	4. Principal business address: 58 DAY ST #2	29
1964 A	Someriille Ma	02144
5. List all hospitals at which you have currently effective privileges: ALWTON-LUE	lesly, waltramweston, Cambiedge, Somerville	Hazzetalo
6. States other than Massachusetts in which you are licensed to practice:	Lone	
	YE YE	S NO
		1
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?		_
Have you been a defendant in any malpractice suit commenced since 10/1/83? Have you been a defendant in any criminal proceeding other than minor traffic offens	es commenced since 10/1/83?	***
Have you been a defendant in any criminal proceeding other than minor traffic offens Has any disciplinary action been taken against you in the last ten years, by any gover	nmental authority, by any hospital or health care facility, or by any	
 Have you been a defendant in any criminal proceeding other than minor traffic offens Has any disciplinary action been taken against you in the last ten years, by any governotessional medical association (International, national, state or local)? 	nmental authority, by any hospital or health care facility, or by any	
 8. Have you been a defendant in any criminal proceeding other than minor traffic offens 9. Has any disciplinary action been taken against you in the last ten years, by any governotessional medical association (International, national, state or local)? 10. Has your privilege to possess, dispense or prescribe controlled substances ever been 	suspended or revoked in this state or any other? A FORMATION IS TRUE. SULLA LINE (MAD) HA	
8. Have you been a defendant in any criminal proceeding other than minor traffic offens 9. Has any disciplinary action been taken against you in the last ten years, by any governotessional medical association (International, national, state or local)? 10. Has your privilege to possess, dispense or prescribe controlled substances ever been 11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: 12. I am an active	suspended or revoked in this state or any other?	

.

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

> AS A REGISTERED **PHYSICIAN**

> > REGISTRATION NO.

47131

LICENSE NUMBER

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 MSOMP

MT JIGHAIVEL ... 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.

Χ... PAY THIS DATE TO BE RENEWED LATE FEE FEE AMOUNT MO DA 100.00 100.00 01 15 84

PLEASE USE THE ENGLOSED RETURN ENVELOPE

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

> COMM, OF MASS. P.O. BOX 6 BOSTON, MASS, 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

3500600471318 011584 10000000009

ELLEN M PENSO

TYPE

CODE

MD

DO NOT WRITE BELOW THIS LINE

PRINT ANY NAME OR ADDRESS CHANGES BELOW

	3 3
3. Home Address: 58	DAY St #229 LERVILLE Ha 02144
SOF	rerville Ha 02144
5. States other than Massachusetts in which you are licensed to practice: 1//A	
6. Has a judgement been returned against you in a malpractice suit since 1/15/82?	YES NO
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 revolent this state or any other?	ked
10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows:*	1 /
*SEE CODE SHEET (YOU MUST ALSO S	SIGNATURE IGN THE FRONT OF THIS (:ARD)



6

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.: 47131 Renewal Date: 01/0	8/1999 I. Current Status: Active
If you want to change your current status, please indicate below:	(Check one). NOV 0.5 1998
Active Retiring (see instructions)	active (see below *)
2. Other Name(s), if any, under which you were licensed:	Please make corrections (type or print) Other Name(s):
3. A) Mailing/Home Address: ELLEN M PENSO, M.D.	Mailing Address: City/Town: Zip: Country:
B) Business Address: 58 DAY STREET STE 229 SOMERVILLE, MA 02144-2800	Other Address: City/Town; Zip: Country:
Home Phone: Business Phone: (617) 628-3710	Home: () Business: () Date of Birth: (M/D/Y):/_ / Sex :
 4. A) Date of Birth: Sex: F B) SS#: 5. A) Name of Medical School: 	SS#: Sex WI Full Name of Medical School:
University of Miami School of Medicine B) Year Graduated: 1977 C) Degree: MD 6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass.	Year Graduated: Degree: M.D D.O. Code(s) Hours Per Week in Massachusetts
GYN 60 Gynecology	If OS, Print Specialty:
7. Current American Board of Medical Specialties Certification (S	See Table 2) Code: Code:
8. Drug License Numbers, if any: A) Federal (DEA): B) Massachusetts:	Federal (DEA):
9. A) Other states where you are now licensed to practice Abbr: P) States where you may licensed to practice.	Abbr:
B) States where you previously were licensed to practice Abbr:	Abbr:

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

P	PRINT NAME AND NUMBER: Last Name: Registration Number:	4713	1/_
li ti e:	0. Current health care facilities at which you have completed the credentialing process for the provision of patient che codes from Table 3 and place a check mark next to those health care facilities where you have admitting privilege ach facility, write the approximate percentage of patient care hours that you provide in each facility.	s (AP). N	ext to
F	Facility Code: 75/ (AP) 100 % Facility Code: 71/ (AP) 0 % Facility Code: 299/	(AP) _ <i>Ò</i>	%
F	Facility Code:/ (AP) % Facility Code:/_ (AP) % Facility Code:/	(AP)	
H	f 999, print name(s):		
11	1. My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit		
	Name of Insurer: PROMUTUAL Alternatively, indicate as follows:		
I a	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		
Pl	lease explain exemption:		
12	. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one	Yes	N
	. A. What is your principal work setting? (See Table 4) _/5_		
	R Care of nationts in Massachusetts (see instruction booklet)		
	1) Average weekly hours involved in: a) outpatient care 5 / hrs/wk b) inpatient care 6 hrs/w	<i>v</i> k	
	2) What is the approximate percentage of your patient care hours in primary care? 95%		
P/	ART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
	sestions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each ques	tion Duos	dda
	tails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in		
	finitions. You must answer ALL questions, or this form will be returned to you and your license renewal may		
		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.	. <u>CLAIMS RESOLVED</u> : 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? X Yes		No
	☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ Training Prog	-	ption
See	E Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applications		•
	Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee school		nt.
•	Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns at Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the		
•	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		
•	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R	_	
Sig	nature: Cellenous Date: //	12 19	28

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



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

Physician Registration Renewal Application

Before	proceeding	, piease	read the	instruction	booklet.

 Copy this form and all attachments for your own records; you will 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.: 47131 Renewal Date: 01/08/9 1. Activity Status: Active Retiring (Check only one) Inactive *(see below) Do not wis 2. Other Name(s), if any, under which you were licensed:	(see instructions)
3. A)Mailing/Home Address: ELLEN M PENSO, M.D.	Other Name(s): IN MEDICINE Mailing Address: State: Zip: Country:
B)Business Address: 58 DAY ST STE 229 SOMERVILLE, MA 02144-2800	Other Address: City/Town: Zip: Country:
Home Phone: Business Phone: (617) 628-3710 4. A) Date of Birth: B) Lic. Issue Date: 01/12/81 C) Sex: F B) Lic. Issue Date: 01/12/81 D) SS#:	Home: () Business: () Date of Birth (M/D/Y): / / Sex (M/F): Lic. Issue Date (M/D/Y): / / SS#: Full Name of Medical School:
University of Miami School of Medicine B) Year Graduated: 77 C) Degree: MD 6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 60 Gynecology	Year Graduated: Degree (MD/DO): Code(s) Hours Per Week in Mass If OS, Print Specialty:

Cuitoni	MINOLIGHT	DOMIN OF	MICHICAL	pheciaines	Certification	(Dec	Lanic 2
Code:	OG	Code:					

8. Drug License Numbers, if any:

A) Federal (DEA):

B) Massachusetts:

9. A) Other states where you are now licensed to practice Abbr:

B) States where you previously were licensed to practice Abbr:

Code:	Code:
Federal (DEA): _ Mass: _	
Abbr:	
Abbr:	

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

	125 NISO (13/2)
PF	RINT NAME AND NUMBER: Last Name: PENSO Registration Number: 47/3/
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: 5 / (AP) Facility Code: 29 / (AP) Facility Code: 1 / (AP) Facility Code: 7 / (AP) Facility Code: 7 / (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:
11.	My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit Name of Insurer: PRUMUTUAL
	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)
	A. What is your principal work setting? (See Table 4)
	B. Care of patients in Massachusetts (see instruction booklet).
	1) Average weekly hours involved in: a) outpatient care 54 hrs/wk b) inpatient care 6 hrs/wk
	2) What is the approximate percentage of your patient care hours in primary care? 95 %
n	
	ART A
Qu det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide alls on Form R for all YES answers. Refer to the instruction booklet for additional information and definitions.
IN	THE PAST TWO (2) YEARS:
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?
	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?
	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
	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.
ligr	RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED. Date:// 12/96

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 Fe		Correction of Mailing Address	
Mailing Address:		Address (Mailing):	
ELLEN M PENSO, M.D.		Address (Marinig).	
	.•	Markey .	
	•	Anna	*
		ARNOLD L. SPERLING, M.D.	
Directions: Before proceeding, please real			/
· Failure to renew in a timely manner w	GYNECOL	PGY, INFERTILITY AND	
ability to practice medicine in the Comr		PGY, INFERTILITY AND GYNECOLOGIC SURGERY	
- Add late fee if necessary.	400 -		
-	280 BOSTON POST ROAD		
- Make a copy of this form and all atta-	""^"LAND. MA 01770		i.
credentialing and other purposes. The Be	(508) 358-5707	58 DAY STRE	ET .
See instructions on detachable coupon		SOMERVILLE, MA 021	44
- acc management on demonatore combon		(617) 628-37	10
	January 8, 1997		
D. D. L. A. J. Y. C.	, -, 1337		
Pre-Printed Information			
 Other name(s), if any, under which y 	Board of Registr		7
	10 West Street	ation in Medicine	
2 Business Address:	Boston, MA 0211		
58 DAY STREET #229	-51517, MA 0211	1	
SOMERVILLE, MA 021			
DOMERVILLE, MA 021	Please		
	Registre send me a	CODY of my	
3. Date of Birth:	Registration in Me	copy of my most recent Board Of edicine Physician Registration	- 1
Lic. Issue Date: 01/12/81	Renewal Application	on Form Registration	
dic. 1330 Bate. 01/12/81	•	or torin,	
U Ph	C:		
Home Phone Busin	Sincerely	واسر	— I
(61	2,-3		I
4. Name of Medical School:	10.	,	
University of Mia	- C	s	
Medicine		MAD MA	
Year Graduated: 77	Ellen M. Penso, M.		- 1
	· chso, M.	U.	
5. a) Other states where you are no	rmb		
b) States where you previously			
· · · · · ·	Enclosure: \$3.00 ch		
6. Specialty Code(s) (See Table 1	\$3.00 cl	neck	
Code Hours per Week			1
OBG 60 Obste			
GYN 0 Gynec			
arre a gluss			
7. If you are currently Americar			
Code: OG			
Code. OG			-
8. Drug license number(s), if as			
Q Activity Status, T			
9. Activity Status: I am appl			

• I hereby certify that if requesting Inactive status, 1 was not pro-

10. a) Current health care facility(ies) at which you have completed the credentialing process for the production of the	provision of patient care. Su		
codes from Table 3 and place a check mark next to those facilities where you have admitting privileges Facility Code:	ity Code: 299/	(AP)	
	lity Code: /	-	
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 year
(See Table 3)			
Facility Code: Facili	ode: Facility	Code:	
If 999, write name(s):	WA 41 44		*********
11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit List Insurer: MASS, MODICAL MODESTIONAL TUSTICAL SSAN.			
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medi (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: State how otherwise exempt:			
12. Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow?	Yes No _X (C	heck one)	
13. a) What is your principal work setting? (See Table 4)			
b) Care of patients in Massachusetts (See instruction booklet.)	42		
i) How many hours per typical week are you currently involved in outpatient care in Mass? ii) How many hours per typical week are you currently involved in inpatient care in Mass?	hrs/wk		
 n) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? 			
(See instructions for definition of primary care.)	<u>85</u> %		
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional inform		letails on	
IN THE PAST TWO YEARS:		YES	NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet be 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 whether or not a lawsuit was filed in relation to the claim?	or otherwise resolved,		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice since a partial conduct in the practice of medicine, been filed against you by a patient, or been settled, as resolved?	tice medicine, or your pro- djudicated or otherwise		
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 standar 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 su 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 re-	eason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcha have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquisibility insurance provider?	uiry by a professional		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your abi			
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your a	bility to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reasonal condition?	y		
25. I have completed my CME requirements in the two years preceding my renewal date: Yes	•		******
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with the companion of			
· Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more	re than the Medicare reaso	mable char	ges.
 Pursuant to G.L. c. 62 C, sec. 49A, I bereby certify under the pains and penalties of perjury to I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are requeven 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. 	fred under law. NOTE: 1	This applies	•
G.L. c. 119, sec. 51A. I hereby certify under the pains and penalties of perjury that all information on this form and			
. I hereby coretty and or the parties and permitted or parties of parties and the parties and permitted or			

			14232.
·•			
PHYSICIAN INFORMATION			
ELLEN irst Name	M	PENSO Last Name	······································
irst Name	Middle Initial	Last Name	Suff
ake changes to name here			
lass License #_47131		First Issue Da	ntc 01/12/81
icense Status Active	•		
	<u> </u>	lospital Affiliation	
58 Day St. Ste 229 Somerville, MA 02144-2800		ewton-Wellesley Hospital omerville Hospital	
U.S.A.	D ₀	eaconess-Waltham Hospital	
(617) 628-3710	N	ew England Medical Center Hospitals	
Make address corrections here:	idake a	my corrections to above here: Mt_AUBULN #05ptfal	

		74	
Insurance Plan Affiliation:		s Held in Other States:	,
	License	s Held in Other States:	
Insurance Plan Affiliation VETS, PRECIM, BAYSTETE, HHU B	License	s Held in Other States: Accepting New Pa	atients? Ves No
VETS, PILGRIM, BAYSTATE, HAVE B	License	s Held in Other States: Accepting New Pa	atients? Ves No

University of Miami School of Medicine Medical School

University of Miami School of Medicine	MD	77	
Medical School L)egree	Date	*********
Make corrections here		The state of the s	
Residency Program(s) APFILIATED HOSPITHIS	1977	1981 End	
Residency Program(s) APPILIATED HOSPITHIS	Start	End	
Residency Program(s)	Start	LJ.W.	
B 11 B 7		End	
Residency Program(s)	Start		
III. SPECIALTY	BOARD CERTIFICA	<u>TION</u>	
Primary Specialty: Obstetrics and Gynecology	Certifying Board Name:	Board of Obstetrics and Gynecology	y
Secondary Specialty: Gynecology	Certifying Board Name:		
Make any corrections here:	Make any corrections her	e: ^	
paining Speciatry - Gyrecology	AMORICAN)	BOARD OF	
SECONDARY SPECIALTY - none	N2 NE	TRICS & Cynecology	la la
and the state of t	1981	of the best of the second of t	
	1.1.2.9		•••••

Board of Registration in Medicine

Physician Profile

	Nature	husetts Board of Registration in Medic Date	Board Action
			2000001
	HOSPITAL DISCIPLINE		
	Hospital	Date	Disciplinary Action
1	CRIMINAL CONVICTIONS The Board of Registration is unable to obtain accincluded when the court system is fully computer of complaint	ized. Please list any criminal convicti	ons. Include conviction date and nature
	MALPRACTICE Details of claims paid for Dr. PENSO		of Years in Practice: #
	Date Amount Paid 0,0000	Basis for Complain	ıt
	Date Amount Paid	Basis for Complain	f
	Zinoant i gig	Basis for Complain	t
	DateAmount Paid	Basis for Complain	ŧ
	Date Amount Paid	Basis for Complain	t
	Date Amount Paid	Basis for Complain	t
	PHYSICIAN HONORS & PEER-REVIEW	WED PUBLICATIONS hich you have contributed and any awa	
	professional recognition you have been given.	the transfer and an annual man	ards for community service or

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

Board of Registration in Medicine

Physician Profile

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 F	I OPPOSION OF MORENA A APPOSE.
Mailing Address:	Address (Mailing):
Dr. ELLEN M PENSO	
v.	City/Town:
	State:Country Code (See Table 1):
	County Coo (500 1 act 1 /)
Directions: Staple check to bottom of form. Add late fee if necessar. • Questions 1-8 include information from Board files. Please correct as a provided on the right hand side of the page.	mecessary in the boxes M.R. NOV 2.7 1992
 Before proceeding, please read the instruction booklet. Some questions Make a copy of this form and all attachments for your own records for credentialing and other purposes. The Board will charge a fee for 	s - you will need copies pr. NUV 27 1992 each copy it provides.
 Enclose the \$250.00 renewal fee by means of a certified check, money payable to the Commonwealth of Massachusetts. 	order or personal check made
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 (Home):
	City/Town: Zip:
	Country Code: If 999 print Country:
b) Address (Business):	Address (Business):
	City/Town: Country Code: If 999 print Country:
DU DAY STREET #229	Country Code: If 999 print Country:
SOMERVILLE, MA 02144-	
3. Date of Birth: Sex; F	Date of Birth (M/D/Y): Sex (M/F):
Lic. Issue Date: 01/12/01 SS#:	Lic. Issue Date (M/D/Y):/ SS#:
Telephone Number:	Telephone Number:
Home Business	Home: () Business: ()
(617)628-3710	Full Name of Medical School:
4. Name of Medical School: University of Miami School	
of Medicine	Year Graduated: Degree (MD/DO):
Year Graduated: 77 Degree: MD	
5. a) Other states where you are now licensed to practice (Abbr):b) States where you previously were licensed to practice (Abbr):	
	Code Hours per Week in Mass.
6. Specialty Code(s) (See Table 2): Code Hours per Week in Mass.	<u>GYN</u> <u>60</u>
006 60 Obstetrics and Gynecology	If OS, print specialty:
7. a) If you are currently American Specialty Board Certified, enter Codes Code: 0 6 Code:	s: (See Table 3) Code: Code:
b) If you previously were American Specialty Board certified, but are n please enter codes of prior certification: (See Table 3);	Code: Code:
Code: Code:	
8. Drug License Number(s), if any: a) Federal (DEA) b) State (MA)	Federal (DEA): State (MA):
9. I have completed my CME requirements in the two years preceding my	
You must fill out a separate Waiver Form. The waiver must be granted CME requirements. Do not submit documentation of your CMEs with	

PENSA 1171	7 /
PRINT NAME AND NUMBER: Physician Last Name: PENSO Registration Number: 47/3	21
10. Activity Status: I am applying to be registered with the following status: Active X Inactive	
I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.	
11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER or (b) LETTER OF CREDIT If applicable, check List Insurer:	k one.
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). Feeiling Code: () 17 5 / (AP) Feeiling Code: () 16 7 / (AP) Feeiling Code: () 9 / (AP)	
admitting privileges (AP). Facility Code: 0 7 5 / V (AP) Facility Code: 0 6 7 / V (AP) Facility Code: 0 0 1 / V (AP) Facility Code: 1 0 8 / V (AP) Facility Code: 1 (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 yea (See Table 4.)	rs.
Facility Code: Facility Cod	
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)	
13 69 6 3 3 4 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
i) How many hours per typical week are you currently involved in outpatient care in MA? 54 hrs/wk in MA ii) How many hours per typical week are you currently involved in inpatient care in MA? 64 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?	NO
Yes	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	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?	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 look denied a medical license for any reason?	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 local 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?	NO
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15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?	
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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?	ges.



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		Renewal Date	For Office Use Only
47131 ACTIV			M.R. Pr. Bd
ប់វិត ⊑	LLEN M PENS	50	Bk.
			Ch. D.E
Directions:			
Questions 1-7 include info			as necessary.
 Before proceeding, pleas Answer all non-optional q 	e read the instruction westions completely.	booklet. (The instructions speci	ify which questions are optional.)
 Make a copy of this form : \$3.00 plus postage for ea. 	and all attachments fi ch copy fumished.	or your own recordsyo	ou must give health care facilities copies for credentialing purposes. The Board charg
 Enclose the \$150.00 rene Activity Status: 	wel fee by means of	e certified check, mone	y order or personal check made payable to the Commonwealth of Massachusetts.
am applying to be registere			Inactive
Printed information			Corrections of Pre-Printed Information
l. Other Name(s), if any, u	ınder which you were	licensed:	Name:
. a) Address (Home):			10 NOTE:
a) Auchoss (Floring).			Address: City/Town
			State: //Z/p:
lat Address (Dustages)			Country Code: (If 999 with Country):
l. b) Address (Business):	#22G		Address: City/Town:
Z THE STREET	PELT		State: Zlp: 4//
AM KELLIVALFO	02144-		Country Code: (if 999, write Country): /**/
. Date of Birth:	Sex: g		Date of Birth (M/D/Y): Lic. issue Date(M/D/Y): / SSN #:
Lic. Issue Date: 31/1	2/31 SSN #:		Lic. issue Date(M/D/Y): / / SSN #:
Telephone Number: Home	Business		Home: Business: (6/7) 628-37/0
TOME		628-6176	nulle busiless.(4)1) 426-3//0
. Medical School Code: F Name of School:	LOU2 Year Gra	duated: 77 Degree:	School Code: Year Graduated: Degree (MD/DO): If 99999, write School:
University o a) Other States where you	f Fiami Sc	hool of Medi	icin
b) States where you previo			
	-	·	
. Specialty Code(s) (See Code Hours pe	<i>Table 3)</i> : er Week in Mess.		Code Hours per Week in Mass.
USE 0		s and Gyned	
Ü		s and dynet	
			If OS, write specialty:
a) Are you American Spec	lalty Board Certified?	(Y/N) _Y 7,b) If Y	ES, Enter Codes:
		1	Gynecology Code:
Code:			Code:
. Drug License Number(s)		Federal (DEA) State (MA) #M	b) How many DEA nos. do you have?
I have completed my C. (You must fill out a separ	rate Waiver Form. Th	e waiver must be grant	ted by the Board before your license will be renewed.) See Instructions for CME
requirements. Do not su	ubmit documentation	of your CME's with you	r renewal application.
OM - 9/90 - P813971			[For Office Use Only: Waiver Granted Date: / /

FILL IN NAME AND NUMBER: PSNSO Registration No.: 4713L					
10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER or (b) LETTER OF CREDIT					
List Insurer: J.U.A.o.F.MASS. 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 exampt):					
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: 75 / (AP) Facility Code: 1 / (AP) Facility Code: 1 08 / (AP)					
Facility Code: 67 /V(AP) Facility Code: 29/V(AP) Facility Code:/(AP)					
If 999, write Name(s):					
Additional Hospitals at which you <u>previously held privileges and other Health Care Facilities with which you were associated in the past 4 years.</u> (See Table 5.)					
Facility Code: Facili					
# 999, write Name(s):					
12. Post Graduate Training In Massachusetts (MA) (See instruction bookiet.) a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes No (Check one.)					
b) If you are in a MA program, are you a i) Residentii) 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 <i>outpatient</i> care in MA? b) How many hours per typical week are you currently involved in <i>inpatient</i> care in MA? c hrs./wk. in MA.					
14. Principal Work Setting. a) What is your principal work setting? (See Table 6) 15					
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.					
Refer to the instruction booklet for additional information.					
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)?					
Refer to the Instruction booklet for additional information. Yes 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?					
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)?					
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Refer to the instruction booklet for additional information. Yes No 16. Has any pending or new medical malpractice claim been made against you (whether or not a lawauit was filed in relation to the claim)? 17. Are any formal disciplinary charges pending or new criminal proceeding other than a minor traffic offense? 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?					
Refer to the instruction booklet for additional information. 16. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?					

BOARD OF REGISTRATION IN MEDICINE

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

LICENSE NUMBER		PAY THIS	FEE	DATE TO BE RENEWED			LATE FEE	
CODE	TYPE	REGISTRATION NO.	AMOUNT		MO	DA	YR	ENTETER
MD	1	47131	\$100	100	01	08	87	

ELLEN M PENSO

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

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

K_{i}	COLLAGE			
1. Print Name:	D.O.? (Check One.) 5. Date of Graduation:	2. Date of Birth: MONTH	DAY	YEAR
Which Boards? 7. Principal Specialty(ies): QBSHETTRICS Y GYNACOLOGY 9. Home address: SAME AS ABOVE	8. Principal work setting: 10. Principal business address:	PRIVATE OFFICE SAME AS AB	ea/e	
1. List all hospitals at which you have currently effective privileges: 2. List all hospitals at which you have held privileges in the past 20 years: 3. States other than Massachusetts in which you are presently licensed to practice.	SAME AS ABOVE	ton Hospital, Shwerville	Hospirm, O	MARIDER HOSPITAL
4. List any other states where you were previously licensed to practice:	7,70.02		YES	NO
 Has any medical malpractice claim been made against you in the last ten years Have you, at any time, been a defendant in any criminal proceeding other than in the second of /li>	minor traffic offenses? n taken against you in the last ten yea association (international, national, s	rs, by any governmental tate or local)?	-	
9. Have you ever withdrawn an application for medical licensure or been denied a	medical license for any reason?			
0. Have you ever had any mental lliness which has impaired your ability to practice	e medicine or to function as a studen	of medicine?	_	
 Have you ever had an organic illness which has impaired your ability to practice 	medicine or to function as a student	of medicine?	_	
2. Are you now, or have you been in the past, dependent upon alcohol or drugs?				
3. Have you ever, for any reason, lost American Specialty Board Certification? 4. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?			-	
5. I have completed my C.M.E. requirements in the two years ending on the renew	al date as follows: Completion	U of 100 HES of CH	ε	
3. I am an active inactive practitioner. (Check One.)		*		
HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION URSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OF BLE CHARGE FOR MY SERVICES.	R COLLECT FROM A MEDICARE BEN	EFICIARY MORE THAN THE N	MEDICARE RE	ASON-
UR\$UANT TO M.G.L. C. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJI ETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NOTE:		GE AND BELIEF, HAVE FILED OUT-OF STATE OR OUT OF		
(See F	DATE:	SIGNATURE ///	14/86	

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 47131 ACTIVE \$250.00 01/08/95 \$25.00 Mailing Address: ELLEN M PENSO, M.D.	
Directions: Before proceeding, please read the instruction booklet. Some of Failure to renew in a timely manner will cause your license to lapse at ability to practice medicine in the Commonwealth. (See enclosed latter • Add late fee if necessary. • Make a copy of this form and all attachments for your own records credentialing and other purposes. The Board will charge a fee for each cop • See instructions on detachable coupon at bottom of this page.	nd may affect your). you will need copies for
Pre-Printed Information 1. Other name(s), if any, under which you were licensed: 2. Business Address: 58 DAY STREET #229 SOMERVILLE, MA 02144	Corrections of Pre-Printed Information Name: Address: City/Town: State: Country:
3. Date of Birth: Lic. Issue Date: 01/12/81 SS#: Home Phone Business Phone (617) 628-3710 4. Name of Medical School: University of Miami School of	Date of Birth (M/D/Y):
Medicine Year Graduated: 77 Degree: MD 5. B) Other states where you are now licensed to practice (Abbr): b) States where you previously were licensed to practice (Abbr): 6. Specialty Code(s) (See Table 1): Code Hours per Week in Mass.	Year Graduated: Degree (MD/DO):
OBG 60 Obstetrics and Gynecology GYN 0 Gynecology 7. If you are currently American Specialty Board certified, enter codes: (Secondary Code: OG Code: 8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts 9. Activity Status: I am applying to be registered with the following status:	Code: Federal (DEA): Mass:

PRINT NAME AND NUMBER: Physician Last Name: PENSO Registration Number: 47/	3/
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:	
Facility Code: O O I / X (AP) Facility Code: /(AP) Facility Code: /(AP)	
If 999, print name(s):	
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the par (See Table 3) Facility Code: Facility Co	•
If 999, write name(s):	
11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit If applicable, check one. List Insurer: MASS. MODICAL MODESSIONAL FASAME. Assam.	
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I at (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: State how otherwise exempt:	
12. Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow? Yes No _X_ (Check one)	
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? ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)	
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:	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?	
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	water-
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 charge to G. C. and G. and G. C. and G. and G. C. and G. and G. C. and G. and G. C. and G. an	-
 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 have flied all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applie even if you reside out-of-state or out of the United States. 	25
 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 G.L. c. 119, sec. 51A. 	by
• 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: Seyensour Date: 12/19/94	



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

000197

Board Use Only: Registration No. 47131	Status	Fee \$150	Renewal Date 01/08/89	., 12		1	1
	LLEN M		<u>V1/V8/87</u>		M. Pr		
					31 - 1 31 - 1	E. V	VE DE
mportant;				\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	49/		
form can result in d Print legibly or type y Answer all non-optio Sign the renewal app Make a copy of this t	isciplinary ac our answers nai question olication at th form and all a	tion. 9 (f <u>ront and t</u> e bottom of p attachments i	e <u>eck</u> of form) com page one and fill li for your own reco	pleting this form. Op not delegate to ' ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! !	hat the Board air e paragraph abover health care facil	eady has the inform e the signature. itles copies for crede:	ation. ntialing purposes.
	PS	NSO		.(FIRST:)	511501		M
. a) Name (LAST:)						. 4 6	(M.l.:) <u>//</u>
							- •
. a) Address (Mailing):	JAME A	S ADOVE				
. b) Address (Home)							
c) Address (Busine	58):	58 DAY	St #229	Somerville MA	02.144		
. d) Telephone (Busi	ness): (<u>6)</u> /	7)628	-3710 E	tension 2. e) Telephone	(Home) (Optiona	<i>l</i>):	
. Date of Birth (MO/i					Social Security No	,	
a) Medical School	Code (See Ta	ble 1): F	002 11999	99, write Name:		PAPER NO PORT OF THE PARENT OF	
b) Year Graduated:	1977	6. c)	Degree: M.D.	D.O			
d) Country: U.S	Canada	Code if 0	Other (See Table 2): # 999, write Name:			
. Work Setting (Circle	s and Indicat	a Percent(%)					
10 Hospital	_	%	15 Private			ship/Group Practice	%
25 Clinic		%		Health Center%	35 Nursing		%
40 HMO Facility 55 Government		70 %		tional Institution% Commercial Setting %	50 Medical 99 Other	Society	⁷⁶
Professional Activit 10 Resident or 30 Administrativ 50 Medical Res	Fellow re Activities earch	% %	20 Prac 40 Med 99 Othe	tice involving Direct Patient Care cal Teaching r	/00 % %	(see your w (MO/DA/YF	Lic, Issue Date all certificate)
. Specialty Code (Se If OS, specify:	ee Table 3): (B & Pero	ent of Practice Ti	me: / U / % Specialty Code:	Percent of	Practice Time:	.%
0. a) Are you Americ	an Specialty	Board Certiff	ed? (Y/N)	10. b) If YES, circle which Board(s):			
A Board of CRS Board of Board of EM Board of IM Board	of Aliergy & In of Anesthesio of Colon & Re of Dermatolog of Emergency of Family Pra- of Internal Me of Neurologic	logy otal Surgery y Medicine ctice dicine	OS OT PA PE	Board of Nuclear Medicine Board of Obstetrice & Gynecology Board of Orthopedic Surgery Board of Otolaryngology Board of Pathology Board of Pediatrics Board of Physical Medicine & Rehal	PM Bo PN Bo R Bo S Bo TS Bo U Bo	ard of Plastic Surgery ard of Preventive Me ard of Psychlatry & N ard of Radiology ard of Surgery ard of Thoracic Surge ard of Urology	dioine eurology
	-			and other Health Care Facilities with		included: Parcent of E	vantina Tima at anat
(See Table 4.) Facility Code: (Facility Code: (Code: 108 0 % Code: 067 0 %		Ity Code: 2 9 9	
						and the second of the second o	
	oitals at which	1 you <u>previo</u> :	usl <u>v held privileg</u> e	e and other Health Care Facilities w	ith which you were	a associated in the pa	st 10 years.
(See Table 4.) Facility Code:	065	Facil	Ity Code:	Facility Code: F	acility Code	Facility Cod	e:
_						1001119 000	
I hereby certify that	t if requestin	g INACTIVE	status, i will not or collect from a	practice medicine in Massachuse Medicare beneficiary more than th a of perjury that, to my beat knowl alred under law. Note: This applie	its. na Medicaro reas	_	•
			that all informa	tion on this form—front and back a	nd (#) attac	hed pages—is true.	-
			1	Wengeno			

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2 Fill in name and number. Physician Last Name: Registration No.: 47/3/ 12. a) Other States where you are now licensed to practice (Abbreviate): 12. b) States where you previously were licensed to practice (Abbreviate): 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 walver.) Category I: 29 hrs., (Risk-Management: 1 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.). U. A. 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 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)?...... 15. Have you been a detendant 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. 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 litness which has impaired your ability to practice medicine or to function as a student of medicine?..... 21. Have you had an organic liness 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):



Physician Name: Ellen M Penso, M.D. License No.: 47131

Current Status: Active License Expiration Date: 1/8/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 241 Boston Post Road

3 A Wayland

Massachusetts - 01778 United States of America

Home Address:

Business Address: 241 Boston Post Road

3 A

Wayland

Massachusetts - 01778 United States of America

(508) 358-5707

3) Email Address:

4) Fax Number: (508) 358-5709

5) Specialties Gynecology

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

Subspecialty

Information

ABMS/AOA **Board Name** Certification **ABMS**

Obstetrics and Gynecology Obstetrics & Gynecology

7) Drug License Numbers

Massachusetts Federal (DEA) Federal (DEA) XS

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

9) States where you were previously licensed None Reported

10) Work Sites

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

WorkSite Location Newton-Wellesley Hospital Newton

Page 1 of 5 Date: 11/17/2012 Time: 4:11 PM



Physician Name: Ellen M Penso, M.D. License No.: 47131

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wk

b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Policy Start Date

Policy End Date

Policy Type

Coverys

06/11/2012

06/11/2013

Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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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?

Page 2 of 5 Date: 11/17/2012 Time: 4:11 PM



Physician Name: Ellen M Penso, M.D. License No.: 47131

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)

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Physician Name: Ellen M Penso, M.D. License No.: 47131

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?

Page 4 of 5 Date: 11/17/2012 Time: 4:11 PM



Physician Name: Ellen M Penso, M.D. License No.: 47131

Compliance with Legal Responsibilities

Online profile:

XI have reviewed my Physician Profile and confirm that the information is accurate.

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10)I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L.c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.
- 13) am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14)I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- **15)**I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.

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Physician Name: Ellen M Penso, M.D. License No.: 47131

Current Status: Active License Expiration Date: 1/8/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 241 Boston Post Road

> 3 A Wayland

Massachusetts - 01778 United States of America

Home Address:

Business Address: 241 Boston Post Road

3 A

Wayland

Massachusetts - 01778 United States of America

(508) 358-5707

3) Email Address:

4) Fax Number: (508) 358-5709

5) Specialties Gynecology

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

Information

ABMS/AOA **Board Name** Certification

Subspecialty

Obstetrics and Gynecology ABMS Obstetrics & Gynecology

7) Drug License Numbers

Massachusetts Federal (DEA) XS Federal (DEA)

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

9) States where you were previously licensed None Reported

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private

office, clinics, nursing homes, etc

WorkSite Location Newton-Wellesley Hospital Newton

Page 1 of 4 Date: 10/31/2010 Time: 1:30 PM



Physician Name: Ellen M Penso, M.D. License No.: 47131

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wk

b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier Policy Start Date

Policy End Date

Policy Type

Physicians Insurance Agency of Massachuse 06/11/2010

06/11/2011

Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

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

18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
- b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
- c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?
- d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?
- 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?
- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Page 2 of 4 Date: 10/31/2010 Time: 1:30 PM



Physician Name: Ellen M Penso, M.D. License No.: 47131

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?

Date: 10/31/2010 Time: 1:30 PM Page 3 of 4



Physician Name: Ellen M Penso, M.D. License No.: 47131

Compliance with Legal Responsibilities

Online profile:

XI have reviewed my Physician Profile and confirm that the information is accurate.

- 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) 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)! understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
 - I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
- Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.

Page 4 of 4 Date: 10/31/2010 Time: 1:30 PM



Physician Name: Ellen M Penso, M.D.

License No.: 47131

License Expiration Date: 1/8/2015

Current Status: Active

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

241 Boston Post Road

3 A Waylar

Wayland

Massachusetts - 01778 United States of America

Home Address:

Business Address:

241 Boston Post Road

3 A

Wayland

Massachusetts - 01778 United States of America

(508) 358-5707

3) Email Address:

4) Fax Number: (508) 358-5709

5) Specialties Gynecology

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

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Board Name

Certification

Subspecialty

ABMS/AOA Bo

Obstetrics & Gynecology

Obstetrics and Gynecology

7) Drug License Numbers

Massachusetts

Federal (DEA)

Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

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

WorkSite

Location

Newton-Wellesley Hospital

Newton

Page 1 of 5 Date: 12/10/2014 Time: 11:10 AM



Physician Name: Ellen M Penso, M.D. License No.: 47131

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

Insurance CarrierPolicy Start Date
06/30/2014Policy End Date
06/30/2015Policy Type
Occurrence Policy

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

14) Claims Made

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

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Page 2 of 5 Date: 12/10/2014 Time: 11:10 AM



Physician Name: Ellen M Penso, M.D. License No.: 47131

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes

Page 3 of 5 Date: 12/10/2014 Time: 11:10 AM



Physician Name: Ellen M Penso, M.D. License No.: 47131

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

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Page 4 of 5 Date: 12/10/2014 Time: 11:10 AM



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- 15)I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
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Page 5 of 5 Date: 12/10/2014 Time: 11:10 AM