



Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

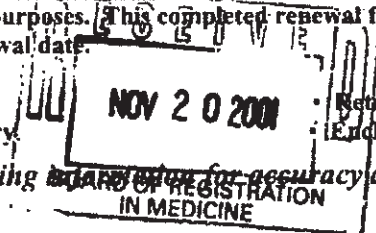
http://www.massmedboard.org

Physician Registration Renewal Application

COMPLETED

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

- Remit \$250.00 for renewal fee.
- Add late fee of \$25.00, if necessary.



- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

REDACTED COPY

1. Current Status: Active

Registration No.: 33613

Renewal Date: 12/26/2001

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

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

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

Please make corrections (type or print)

3. A) Mailing/Business Address:

ELI H NEWBERGER
THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115

B) Home Address:

Home Phone:

Business Phone:

Other Name(s): _____	
Mailing Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Business Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Business Telephone: _____	
Home Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Home Telephone: () _____	
PLEASE NOTE: No P.O. Box addresses for home or business addresses.	

4. a) Date of Birth:

b) Sex: M

c) SS#:

5. a) Name of Medical School:

Yale University School of Medicine

b) Year Graduated: 1966

c) Degree: M.D.

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

Code(s) Hours per Week in Mass.

PD 0 Pediatrics
0

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

8. Drug License Numbers, if any:

a) Federal (DEA):

b) Massachusetts:

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

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

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 139 / ✓ (AP) 100 % Facility Code: / (AP) % Facility Code: / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s):

PRINT YOUR LAST NAME: Newberger

LICENSE NUMBER: 33613

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

Name of Insurer: Controlled Risk Insurance Company of Vermont, Inc. Alternatively, indicate as follows:

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

- a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

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

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

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

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

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

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

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

14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?
17. Have you been charged with any criminal offense, other than a minor traffic violation?
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?

YES NO

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

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

- Pursuant to G.L. c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.
- I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.

Signature: _____

Erin H. Newberger

Date: 11/17/01

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

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

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



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

Before proceeding, please read the instruction booklet.

• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

- Remit \$250.00 for renewal fee.
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope

Registration No.: 33613

Renewal Date: 12/26/1999

1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:

ELI H NEWBERGER
THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115

B) Home Address:

Home Phone:

Business Phone:

4. A) Date of Birth:

Sex: M

B) SS#:

5. A) Name of Medical School:

Yale University School of Medicine

B) Year Graduated: 1966 C) Degree: M.D.

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

Code(s) Hours per Week in Mass.
PD 0 Pediatrics
0

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

Code: PE Code:

8. Drug License Numbers, if any:

A) Federal (DEA):

B) Massachusetts:

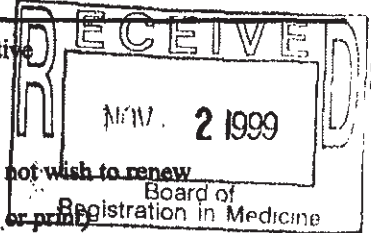
9. A) Other states where you are now licensed to practice

Abbr:

B) States where you previously were licensed to practice

Abbr:

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



Please make corrections (type or print)

Other Name(s):

Mailing Address:

City/Town: State:

Zip: Country:

Other Address:

City/Town: State:

Zip: Country:

Home: ()

Business: (617) 355-7982

Date of Birth: (M/D/Y): / / Sex: ☐ M ☐ F

SS#: - - - - -

Full Name of Medical School:

Year Graduated: Degree: ☐ M.D. ☐ D.O.

Code(s) Hours Per Week in Massachusetts

If OS, Print Specialty:

Code: Code:

Federal (DEA):
Mass: - - - - -

Abbr: - - - - -
Abbr: - - - - -

PRINT NAME AND NUMBER: Last Name: Newberger✓ Registration Number: 33613

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 139 / ✓ (AP) 100 % Facility Code: / (AP) % Facility Code: / (AP) %

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

If 999, print name(s):

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

Name of Insurer: CRICO

Alternatively, indicate as follows:

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

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption:

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

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

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

1) Average weekly hours involved in: a) outpatient care 10 hrs/wk b) inpatient care 10 hrs/wk

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

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

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

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

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

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

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

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

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

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

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

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

Signature:

Date: 10 / 28 / 99

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

BOARD OF REGISTRATION IN MEDICINE

ROOM 1507 -- 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
1986-1988

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

X *Eli H. Newberger, M.D.*

APPLICANT'S SIGNATURE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD		33613	100.00	100.00	01	15	86	

PLEASE PRINT ANY NAME OR ADDRESS
CHANGES BELOW

ELI H NEWBERGER

DO NOT WRITE BELOW THIS LINE

SEE REVERSE SIDE

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 QUESTIONS, 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.



122958
PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS

P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

99944

3500600336131 011586 10000000004

DO NOT FOLD OR
STAPLE THIS FORM

Print Name:

Eli H. Newberger, M.D.

Date of Birth:

Yale

Medical School:

Date of Graduation:

1966

You must read the instructions enclosed with this form to answer questions 1-12.

1. Principal Specialty(ies):

Pediatrics

2. Principal work setting:

Children's Hospital

3. Home address:

4. Principal business address:

300 Longwood Ave.
Boston, MA 02115

5. List all hospitals at which you have currently effective privileges:

Children's Hospital

6. States other than Massachusetts in which you are licensed to practice:

NONE

7. Have you been a defendant in any malpractice suit commenced since 10/1/83?

YES NO

8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?

9. Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows:

Certification by the Dept. of Education of the Mass. Medical Society

12. I am an active ☒ inactive ☐ practitioner. (Check one)

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

Eli H. Newberger, M.D.

SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

I. PHYSICIAN INFORMATION

ELI H NEWBERGER
 First Name Middle Initial Last Name Suffix

Make changes to name here

Mass License # 33613

First Issue Date 08/19/71

License Status Active

Hospital Affiliation

The Children's Hospital
 300 Longwood Avenue
 Boston, MA 02115
 U.S.A.
 (617) 355-7979

Children's Hospital

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation: (through

HMO/Blue

John Hancock

Platinum

Dept. of Medicine,

Children's Hospital)

Licenses Held in Other States:

Accepting New Patients? ☒ Yes ☐ No

Accept Medicaid? ☒ Yes ☐ No

(Please correct as necessary)

II. EDUCATION & TRAINING

Yale University School of Medicine
 Medical School

MD
 Degree

66
 Date

Make corrections here

Intern, Internal Medicine, Yale-New Haven Hospital

7/1/66 - 6/30/67

End

Residency Program(s)

Start

Resident, Pediatrics, Boston Children's Hospital

7/1/69 - 6/30/72

End

Residency Program(s)

Start

End

Residency Program(s)

Start

III. SPECIALTY

Primary Specialty: Pediatrics

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Pediatrics

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

NatureDateBoard Action

None

V. HOSPITAL DISCIPLINEHospitalDateDisciplinary Action

None

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint NONE

VII. MALPRACTICENo. of Years in Practice: # 29

Details of claims paid for Dr. NEWBERGER

Date <u>NONE</u>	Amount Paid <u>0.0000</u>
Date	Amount Paid
Date	Amount Paid
Date	Amount Paid
Date	Amount Paid
Date	Amount Paid
Date	Amount Paid

Basis for Complaint	
Basis for Complaint	
Basis for Complaint	
Basis for Complaint	
Basis for Complaint	
Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, HonorsPublications

1. 1985 Bartoloni Award, Greater Boston Committee for UNICEF
2. 1988 Humanitarian Award, MA Psychological Association
3. 1992 Award for excellence for outstanding research
in the parent-child field, Boston Institute for the Development
of Infants and Parents
4. 1992 Community Achievement Award, B'nai B'rith
Women of MA and the North East Region

see enclosed 5 pages

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

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

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

Registration No.	Status	Fee	Renewal Date	Late Fee
33613	ACTIVE	\$250.00	12/26/95	\$25.00

Mailing Address:

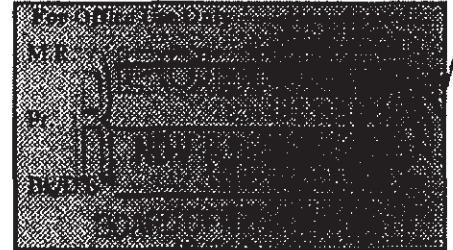
ELI H NEWBERGER, M.D.
THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115

Correction of Mailing Address

Address (Mailing): _____
City/Town: _____
State: _____
Country: _____

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

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



Pre-Printed Information

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

2. Home Address:

3. Date of Birth: _____ Sex: **M**
Lic. Issue Date: **08/19/71** SS#: _____

Home Phone _____ Business Phone **(617) 735-7979**

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

Year Graduated: **66** Degree: **MD**

5. a) 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.
PD	50 Pediatrics

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

Code: **PE** 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: **ACTIVE** ☒ **INACTIVE** _____

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

Corrections of Pre-Printed Information

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

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

Home: () _____ Business: **(617) 355-7979**

Full Name of Medical School: _____

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

Code

Hours per Week in Mass.

_____	_____
_____	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

PRINT NAME AND NUMBER: Physician Last Name: Newberger Registration Number: 33613

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: 139 / ☒ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

If 999, print name(s): _____

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

Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write name(s): _____

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

List Insurer: CRICO

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

(Check One): (i) Not involved in direct/indirect patient care in Massachusetts: _____ (ii) Otherwise exempt: _____

State how otherwise exempt: _____

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

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

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

i) How many hours per typical week are you currently involved in outpatient care in Mass? 20 hrs/wk

ii) How many hours per typical week are you currently involved in inpatient care in Mass? 20 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care?

(See instructions for definition of primary care.) 0 %

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

IN THE PAST TWO YEARS:

YES NO

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

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

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

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

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

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

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

21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? _____

22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine? ..

23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice? ..

24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? ..

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

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

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

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

• Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.

• I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.

Signature: Eli H. Newberger, M.D. Date: 11/15/95

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

Registration No. 3351	Status ACTIVE	Fee \$250.00	Renewal Date 12/26/93	Late Fee \$25.00	Correction of Mailing Address:
Mailing Address: ALI H. NEWBERGER, M.D. THE CHILDREN'S HOSPITAL 300 LONGWOOD AVENUE BOSTON, MA 02115					Address (Mailing): _____
					City/Town: _____
					State: _____
					Country Code (See Table 1): _____

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

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

For Office Use Only	
M.R. _____	NOV 01 1993
Pt. _____	NOV 01 1993
Bk/D.E. _____	

Pre-Printed Information

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

2. a) Address (Home):

b) Address (Business):

THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115

3. Date of Birth: _____ Sex: M
 Lic. Issue Date: 08/19/71 SS#: _____
 Telephone Number:
 Home _____ Business (617) 705-7979

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

Year Graduated: 00 Degree: MD

5. a) 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 2):

Code	Hours per Week in Mass.
50	Pediatrics

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

Code: PE Code:

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

Code: Code:

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

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

Corrections of Pre-Printed Information

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

Date of Birth (M/D/Y): 8/19/71 Sex (M/F): M
 Lic. Issue Date (M/D/Y): 8/19/71 SS#: _____
 Telephone Number:
 Home: () Business: ()
 Full Name of Medical School: _____

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

Code	Hours per Week in Mass.

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

Federal (DEA): _____
 State (MA): _____

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Newberger Registration Number: 33613

10. Activity Status: I am applying to be registered with the following status: Active ☒ Inactive ☐

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ☒ or (b) LETTER OF CREDIT ☐ If applicable, check one.

List Insurer: CRICO

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

(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS: ☐ (ii) OTHERWISE EXEMPT: ☐

(State how otherwise exempt): _____

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 139 / ☒ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

If 999, print name(s): _____

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years.

(See Table 4.)

Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write name(s): _____

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

14. a) What is your principal work setting? (See Table 5) 10

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

i) How many hours per typical week are you currently involved in outpatient care in MA? 8 hrs/wk in MA

ii) How many hours per typical week are you currently involved in inpatient care in MA? 20 hrs/wk in MA

Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question.

Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

YES NO

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____

Ed. H. Newberger, M.D.

Date: 10, 30, 93



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

Registration No.	Status	Fee	Renewal Date	For Office Use Only	
33613	ACTIVE	\$150	12/26/91	M.R.	_____
				Pr.	_____
				Bk.	_____
				Ch.	_____
				D.	_____
				ENTERED NOV 26 1991	

Dr. ELI H NEWBERGER
THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115

Directions:

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

Activity Status:

I am applying to be registered with the following status: Active ☒ Inactive ☐
I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information

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

2. a) Address (Home):

2. b) Address (Business):

THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115-

3. Date of Birth: _____ Sex: M _____
Lic. Issue Date: 08/19/71 SSN # _____
Telephone Number: _____
Home Business

(617) 735-7979

4. Medical School Code: T001 Year Graduated: 86 Degree: MD
Name of School:

Yale University School of Medicine

5. a) Other States where you are now licensed to practice (Abb):

b) States where you previously were licensed to practice (Abb):

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

Code	Hours per Week in Mass.
PD	0 Pediatrics
0	

Corrections of Information

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

Date of Birth (M/D/Y):	____/____/____	Sex (M/F):	_____
Lic. Issue Date (M/D/Y):	____/____/____	SSN #:	_____
Home: ()	Business: ()		
School Code:	Year Graduated:	Degree (MD/DO):	_____
If 99999, write School: _____			

Code	Hours per Week in Mass.
_____	50
_____	_____
If OS, write specialty: _____	

7.a) Are you American Specialty Board Certified? (Y/N) y 7.b) If YES, Enter Codes:

Code: PE Board of Pediatrics
Code: _____

Code: _____
Code: _____

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

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

FILL IN NAME AND NUMBER:

Physician Last Name:

Newberger

Registration No.:

33613

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

List Insurer:

CRICO

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

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: _____

(ii) OTHERWISE EXEMPT: _____

(State how otherwise exempt): _____

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

Facility Code: 1391 (AP) ☒

Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP)

If 999, write Name(s): _____

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

Facility Code: _____

Facility Code: _____

Facility Code: _____

Facility Code: _____

If 999, write Name(s): _____

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

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

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

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

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

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

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

14. Principal Work Setting.

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

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

Yes No

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

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

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

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

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

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

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

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

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

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

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

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

Signature:

E. Newberger, M.D.

Date 10 / 28 / 91



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

Before proceeding, please read the instruction booklet.

• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

The Board will charge a fee for each copy.

• Remit \$250.00 for renewal fee.

• Add late fee of \$25.00, if necessary.

• Return renewal application in **GREEN** envelope.

• Enclose check with coupon in **BLUE** envelope.

Registration No.: **33613**

Renewal Date: **12/26/97**

1. Activity Status: ☒ Active ☐ Retiring (see instructions)
(Check only one) ☐ Inactive *(see below) ☐ Do not wish to renew

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

Corrections (type or print)

3. A) Mailing/Business Address:

**ELI H NEWBERGER, M.D.
THE CHILDREN'S HOSPITAL
300 LONGWOOD AVENUE
BOSTON, MA 02115**

B) Home Address:

Home Phone:

Business Phone: **(617) 355-7979**

4. A) Date of Birth: C) Sex: **M**
B) Lic. Issue Date: **08/19/71** D) SS#:

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

B) Year Graduated: **66** C) Degree: **MD**

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

Code(s) Hours per Week in Mass.
PD 50 Pediatrics

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

Code: **PE** 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:

Other Name(s):	
Mailing Address:	
City/Town:	State:
Zip:	Country:
Other Address:	
City/Town:	State:
Zip:	Country:
Home: ()	
Business: (617) 355-7982	
Date of Birth (M/D/Y):	Sex (M/F):
Lic. Issue Date (M/D/Y):	SS#:
Full Name of Medical School:	
Year Graduated: Degree (MD/DO):	
Code(s)	Hours Per Week in Mass.
PD	25
If OS, Print Specialty:	

Code: Code:

Federal (DEA):
Mass:

Abbr:
Abbr:

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

PRINT NAME AND NUMBER: Last Name: Newberger Registration Number: 336131

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: 134 / ☒ (AP)

Facility Code: _____ / _____ (AP)

Facility Code: / (AP)

Facility Code: _____ / _____ (AP)

Facility Code: 1 (AP)

Facility Code: / (AP)

If 999, print name(s):

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

Facility Code: Facility Code: Facility Code: Facility Code: Facility Code:

If 999, write Name(s):

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

Name of Insurer: CRICO

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption:

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

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

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

1) Average weekly hours involved in: a) outpatient care 15 hrs/wk b) inpatient care 10 hrs/wk

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

PART A

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

IN THE PAST TWO (2) YEARS:

14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?
17. Have you been charged with any criminal offense, other than a minor traffic violation?
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)?

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

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

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

Signature

Ed. H. Newberger, M.D.

Date: 11 / 6 / 97

BOARD OF REGISTRATION IN MEDICINE

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

SOC. SEC.
NUMBER
OPTIONAL

SEE REVERSE SIDE

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

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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

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

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

- Print Name: Eli H. Newberger
- Date of Birth: 1966 MONTH 11 DAY 27 YEAR 1966
- Medical School: Yale Medical School M.D.? ☒ D.O.? ☐ (Check One.)
- Country where Medical School located: U.S.A.
- Date of Graduation: 1966
- American Specialty Board Certified? ☒ (Check if yes.)
Which Boards? Pediatrics
- Principal Specialty(ies): Pediatrics
- Principal work setting: The Children's Hospital
- Home address: _____
- Principal business address: 300 Longwood Ave.
Boston, MA 02115
- List all hospitals at which you have currently effective privileges: The Children's Hospital
- List all hospitals at which you have held privileges in the past 20 years: The Children's Hospital
- States other than Massachusetts in which you are presently licensed to practice: NONE
- List any other states where you were previously licensed to practice: NONE
- Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?
- Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
- Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
- Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?
- Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?
- Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student 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?
- Are you now, or have you been in the past, dependent upon alcohol or drugs?
- Have you ever, for any reason, lost American Specialty Board Certification?
- Have you been denied recertification by one or more specialty boards?
If yes, which one(s)?
- I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: At least 100 hours of Category 1 and 100 hours of categories 2 through 6 at Children's Hospital, Harvard Medical School, and other CME courses.
- I am an active ☒ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE. PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

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

Eli H. Newberger, M.D.
SIGNATURE

DATE: 11/27/87

(See Reverse Side)



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

020104

Board Use Only:

Registration No. Status Fee Renewal Date
\$150

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

EB 11/28/89
ECN 12/1/89

Important:

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

1. a) Name (LAST): Newberger (FIRST): Eli (M.I.): H.

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

2. a) Address (Mailing): The Children's Hospital
300 Longwood Ave., Boston, MA 02115

2. b) Address (Home): _____

2. c) Address (Business): The Children's Hospital
300 Longwood Ave., Boston, MA 02115

2. d) Telephone (Business): (617) 735-7979 Extension: _____ 2. e) Telephone (Home) (Optional): _____

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

6. a) Medical School Code (See Table 1): CT001 If 9999, write Name: _____

6. b) Year Graduated: 1966 6. c) Degree: M.D. ☒ D.O. ☐

6. d) Country: U.S. ☒ Canada ☐ Code if Other (See Table 2): _____ If 999, write Name: _____

7. Work Setting (Circle and indicate Percent(%) of Practice Time):
10 Hospital 100 % 15 Private Office _____ % 20 Partnership/Group Practice _____ %
25 Clinic _____ % 30 Mental Health Center _____ % 35 Nursing Home _____ %
40 HMO Facility _____ % 45 Educational Institution _____ % 50 Medical Society _____ %
55 Government Facility _____ % 60 Plant/Commercial Setting _____ % 99 Other _____ %

8. Professional Activity (Circle and indicate Percent(%) of Professional Time):
10 Resident or Fellow _____ % 20 Practice Involving Direct Patient Care 60 %
30 Administrative Activities 10 % 40 Medical Teaching 10 %
50 Medical Research 20 % 99 Other _____ %
8. b) Mass. Lic. Issue Date (see your wall certificate) (MO/DA/YR): 8/19/90

9. Specialty Code (See Table 3): P D Percent of Practice Time: 100 % Specialty Code: _____ Percent of Practice Time: _____ %
If OS, specify: _____

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

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

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each.
(See Table 4.)
Facility Code: 139 100 % Facility Code: _____ % Facility Code: _____ %
Facility Code: _____ % Facility Code: _____ % Facility Code: _____ %
If 999, write Name(s): _____

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years.
(See Table 4.)
Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____
If 999, write Name(s): _____

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

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

Pursuant to M.G.L. c.52C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. Note: This applies even if you reside out-of-state or out of the country.

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

Signature: E.H. Newberger, M.D.

(150 760/730 2/89)

Date: 11/7/89

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

Fill in name and number. Physician Last Name: Newberger Registration No.: 33613

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 waiver.)
 Category I: 55 hrs., Category II: 35 hrs., (Risk-Management: 10 hrs.); Residency Program in: _____
 Waiver Requested _____ (You must fill out a separate Waiver Form.)
14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ☒ LETTER OF CREDIT ☐. *If applicable, check one and identify the name.*
 Insurer: CRICO Institution Issuing Letter of Credit: _____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one)
 NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ☐ OTHERWISE EXEMPTED ☐ (State how) _____
14. c) Percent of Practice Time in Massachusetts: 100 %

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

15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--See instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?

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

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

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?
23. Have you, for any reason, lost American Specialty Board Certification?
24. Have you been denied recertification by one or more specialty boards? If YES, list Board(s): _____



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

Physician Registration Renewal Application

DEC 23 2003

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

• Remit \$400.00 for renewal fee (non-refundable).

• Add late fee of \$25.00, if necessary.

• Return renewal application in GREEN envelope.

• Enclose check with coupon in BLUE envelope.

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active

Registration No.: 33613

Renewal Date: 12/26/2003

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

☐ Active

☐ Retiring (see instructions)

☐ Inactive (see instructions)

☐ Do not wish to renew

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

Please make corrections (print)

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

A) Mailing/Business Address:

3. ELI H NEWBERGER

B) Home Address:

Home Phone:

Business Phone:

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: () _____

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: _____

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

4. a) Date of Birth:

b) Sex: M

c) SS#:

5. a) Name of Medical School:

Yale University School of Medicine

b) Year Graduated: 1966

c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.
PD	0
Pediatrics	0

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

8. Drug License Numbers, if any:

a) Federal (DEA):

b) Massachusetts:

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

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

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). No affiliations.

Facility Code: 139 / ✓ (AP) 100 % Facility Code: / (AP) % Facility Code: / (AP) %
Facility Code: / (AP) % Facility Code: / (AP) % Facility Code: / (AP) %

If 999, print name(s):

Massachusetts Physician Renewal Application

Physician Name: ELI H NEWBERGER

License No.: 33613

PART A

1) Current Status: Active

Renewal Due Date: 11/28/2005

Birth Date:

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

☒ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone:

☐ Check here to change this address

2c) BUSINESS ADDRESS

92 Evans Road

Brookline, MA 02445

Phone: (617)232-7908

☐ Check here to change this address

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (____) _____

Home address cannot be a Post Office Box

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (____) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

617-331-1897

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Pediatrics	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
Pediatrics	ABMS	Pediatrics	<input checked="" type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: **ELI H NEWBERGER**

License No.: **33613**

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

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

Please make corrections as necessary

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

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

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

Principal Work Setting: Private Office

Change to: _____

Please enter the approximate number of work hours at your principal work setting: **30**

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

No Affiliations ☐

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

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		Approximate # Hours per Week
		Current	Change	
Children's Hospital	<input type="checkbox"/>	Admitting	Adjunct	2
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

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

b) outpatient care 10 hrs/wk Change to: 0 hrs/wk

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

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

☐ Insurance Carrier (complete below)

Current Insurance Carrier: CRICO

Change to: _____

Policy dates: From ___/___/___ To ___/___/___
(required)

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

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

Check one:

☒ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt (Please explain): _____

Massachusetts Physician Renewal Application

Physician Name: **ELI H NEWBERGER**

License No.: **33613**

13) Do you perform any surgery in your office? (See *Renewal Instructions*, page 5.)

Yes

No

If Yes, please complete Form PCA-O "Office Based Surgery"

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

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

YES NO

14) CLAIMS MADE

a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim?

b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?

15) CLAIMS PAID

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

16) OTHER CIVIL LAWSUITS

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

a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?

b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?

17) CRIMINAL CHARGES

a) Have you been charged with any criminal offense during this time period?

b) Are there any criminal charges pending against you today?

c) Have any criminal offenses/charges against you been resolved during this time period?

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

11/30/05 S2 134

Massachusetts Physician Renewal Application

Physician Name: ELI H NEWBERGER

License No.: 33613

PHYSICIAN PROFILE

- ☒ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- ☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: _____

El H. Newberger

Date: 11/27/05

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

Massachusetts Physician Renewal Application

Physician Name: ELI H NEWBERGER

License No.: 33613

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

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

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

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

- ☐ My current NPI is:
- ☐ I have personally applied for an NPI.
- ☐ I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- ☒ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 13 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

2 0 8 0 0 0 0 0 5 x

Provider Taxonomy:

Provider Taxonomy:

Pediatrics

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US):

NY

Country of Birth (if outside the US):

Gender:



Male



Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

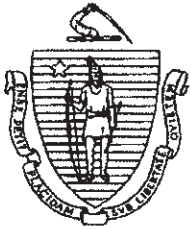
Signature:

Eli H. Newberger

Date:

11 / 27 / 05

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



Commonwealth of Massachusetts Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR
KERRY HEALEY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR
NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

Eli H Newberger M.D.

April 05, 2006

RECEIVED
APR 10 2006
Board of Registration
in Medicine

Dear Dr. Newberger:

License No. **33613**

On your most recent license renewal application, you either supplied the Board of Registration in Medicine with your National Provider Identifier (NPI) number, stated that you have applied for this number or authorized the Board to apply for an NPI number on your behalf. The Center for Medicare Services (CMS) requires authorization from the physician in order to disseminate the NPI number to health care providers or authorized agencies.

Please sign and date the authorization statement to allow the Board of Registration in Medicine to provide your NPI number to any authorized agency, hospital, health plan, or health organization. You must mail this authorization to the Board of Registration in Medicine, 560 Harrison Avenue, G-4, Boston, Massachusetts, 02118.

Please return the original signed NPI authorization form in the envelope provided. CMS requires an original signed authorization form for dissemination of your NPI number to health providers or authorized agencies. We cannot accept a faxed copy of this form. Thank you.

Authorization for NPI Dissemination

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

Signature: _____

Date: _____

License Number: 33613

Renewal Date: 12/26/2005



Visit Our Website At: <http://www.massmedboard.org>

Massachusetts Physician Renewal Application

Physician Name: **Eli H Newberger, M.D.**

License No.: **33613**

PART A

1) Current Status: **Active**

Renewal Due Date: **11/28/2007**

Birth Date: _____

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

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

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone: _____

☐ Check here to change this address

2c) BUSINESS ADDRESS

Phone: _____

☐ Check here to change this address

3) E-mail Address: _____

4) Fax Number: **(617)731-1897**

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (____) _____

Home address cannot be a Post Office Box

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (____) _____

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)

Delete?

List Additional Specialties:

Pediatrics

☐

☐

☐

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

List Certifying Board(s) below:

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Pediatrics	ABMS	Pediatrics	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: **Eli H Newberger, M.D.**

License No.: **33613**

(See Renewal Instructions, page 4.)

7) Drug License Numbers

Corrections: _____

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

9) States where you were previously licensed

10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.

List the names of all work sites in Massachusetts (See above and description on page 4.)	Location (City or Town)	State	Delete?
Children's Hospital Boston			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

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

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

Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:

☐ **Insurance Carrier (complete below)**

Current Insurance Carrier: American Home Assurance Co

Change to: _____

Policy dates: From ___/___/___ To ___/___/___

Type of Policy: ☐ Claims made with tail coverage ☐ Occurrence Policy

(Enclose a copy of the certificate of insurance or the face sheet)

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

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

Check one:

☒ Not involved with direct or indirect patient care in Massachusetts

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt (Please explain): _____

13) Do you perform any surgery in your Massachusetts office? (See Renewal Instructions, page 5.)

Yes

No

If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: **Eli H Newberger, M.D.**

License No.: **33613**

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

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

YES NO

14) CLAIMS MADE a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above). b) PENDING: Are there any unresolved malpractice claims against you today , i.e., any claims that have not been finally settled or finally adjudicated?	
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?	
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?	
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?	
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?	
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?	
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?	
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?	

22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
- b) If no, are you requesting a CME waiver? ☐ Yes ☐ No

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

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

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

Massachusetts Physician Renewal Application

Physician Name: Eli H Newberger, M.D.

License No.: 33613

PART C

Check One:

PHYSICIAN PROFILE

- ☒ I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- ☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (See Renewal Instructions, page 11.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature:

Eli H. Newberger

Date: 11 / 26 / 07

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Eli H Newberger, M.D.

License No.: 33613

Current Status: Active

License Expiration Date: 12/26/2009

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

3) Email Address:

4) Fax Number: (617) 731-1897

5) Specialties

Child Abuse Pediatrics
Developmental-Behavioral Pediat
Pediatrics

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Pediatrics	Pediatrics	

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
Office-Solo Practice	92 Evans Rd., Brookline, Ma 02445



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

11) Care of patients in Massachusetts

Average weekly hours involved in: a) inpatient care 0 hrs/wk
b) outpatient care 2 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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?



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

Compliance with Legal Responsibilities

Online profile:

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Eli H Newberger, M.D.

License No.: 33613

Current Status: Active

License Expiration Date: 12/26/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

3) Email Address:

4) Fax Number: (617) 731-1897

5) Specialties

Child Abuse Pediatrics
Developmental-Behavioral Pediat
Pediatrics

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Pediatrics	Pediatrics	

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
Office-Solo Practice	92 Evans Rd., Brookline, Ma 02445



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

11) Care of patients in Massachusetts

Average weekly hours involved in: a) inpatient care 0 hrs/wk
b) outpatient care 2 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Other

Consultation only.

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?

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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.

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- 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?
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- 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?



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?
- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

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

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



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
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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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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Eli H Newberger, M.D.

License No.: 33613

Current Status: Active

License Expiration Date: 12/26/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

3) Email Address:

4) Fax Number: (617) 731-1897

5) Specialties

Child Abuse Pediatrics
Developmental-Behavioral Pediat
Pediatrics

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

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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

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

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

Yes



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

Physician Name: Eli H Newberger, M.D.

License No.: 33613

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

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

Physician Name: Eli H Newberger, M.D.

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Compliance with Legal Responsibilities

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- ☒ 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.

CURRICULUM VITAE

Eli H. Newberger

June 2, 1998

POOR ORIGINAL COPY

Office Address: Children's Hospital, 300 Longwood Ave., Boston, MA 02115
Home Address:
Place of Birth: New York, New York

Education:

1962 B.A. Yale College
1966 M.D. Yale School of Medicine
1972 M.S. Harvard School of Public Health (Epidemiology)

Postdoctoral Training:

Internship and Residency

1966-1967 Intern, Medicine, Yale-New Haven Hospital, New Haven
1969-1972 Assistant Resident, Pediatrics, Children's Hospital, Boston

Licensure and Certification:

1970 Massachusetts License Registration No. 33613
1973 American Board of Pediatrics, Certificate No. 16639

Academic Appointments:

1972-1976 Instructor in Pediatrics, Harvard Medical School
1976- Lecturer on Maternal and Child Health, Harvard School of Public Health
1976- Assistant Professor of Pediatrics, Harvard Medical School

Hospital Appointments:

1971-1974 Assistant in Medicine, Children's Hospital, Boston
1974-1980 Associate in Medicine, Children's Hospital, Boston
1980- Senior Associate in Medicine, Children's Hospital, Boston

Other Professional Positions:

1967-1969 Peace Corps Physician, Upper Volta (Burkina Faso), West Africa

POOR ORIGINAL COPY

Hospital and Health Care Organization Clinical Responsibilities:

1971-	Medical Director, Child Protection Program, Children's Hospital
1972-	Director, Family Development Program, Children's Hospital
1996-	Chair, Task Force on Medical Education, Working Group on Family Violence
1972-	Attending Physician, Children's Hospital; inpatient and outpatient teaching and clinical supervision of Harvard Medical School students and Children's Hospital interns and residents
1979-97	Director, Clinical Research Training Program on Family Violence, Children's Hospital (National Research Service Award, National Institute of Mental Health)

Major Committee Assignments:

National and Regional

1970-1973	Governor's Committee on Child Abuse (<u>Chairman</u> , Subcommittee on Services)
1972-1980	National Board of Advisors, Parents Anonymous
1974-1975	Advisory Committee, Model Child Abuse Reporting Law Project, Juvenile Justice Standards Project, American Bar Association
1977-1980	Advisory Committee on Protective Services, Massachusetts Department of Public Welfare
1977-1980	Policy Advisory Committee on Child Abuse and Neglect, Massachusetts Office for Children
1978-1980	Pediatric Task Force, Massachusetts Department of Public Health
1979-1982	Governor's Advisory Committee on Children and the Family (<u>Chairman</u> , Subcommittee on Families in Crisis)
1980-1982	Public Member, Advisory Board, National Center on Child Abuse and Neglect Department of Health and Human Services
1981-1984	Board of Directors, National Committee for the Prevention of Child Abuse
1987-1989	Child Protection Services Standards Committee, Child Welfare League of America
1988	Science Selection Committee, Bunting Institute, Radcliffe College
1988-1992	Fatality Review Board, Human Resources Administration, New York City
1988-1991	Child Abuse Prevention Board, Commonwealth of Massachusetts
1989-1994	National Advisory Committee, National Data Archive on Child Abuse and Neglect, Cornell University
1990-1994	Injury Research Grant Review Committee, Centers for Disease Control, U.S. Public Health Service, Atlanta, Georgia
1992-1998	Standing Committee on Continuing Medical Education, Harvard Medical School
1992-1993	Governor's Commission on Foster Care, Commonwealth of Massachusetts
1993-1998	Board of Trustees, Council on Accreditation of Services for Families and Children
1995-96	President, Aesculapian Club, Harvard Medical School
1995-98	Member, Committee on the Assessment of Family Violence Interventions, National Research Council

POOR ORIGINAL COPY

International

- | | |
|-----------|--|
| 1973 | Africare Maternal and Child Health Field Survey Team, Diffa Department, Niger, West Africa |
| 1977-1978 | Multidonor Project Appraisal Mission, Lake Chad Basin Commission, United Nations Development Program, Chad, Niger, and Cameroon, West Africa |
| 1979 | Medical Research Appraisal Project, U.S. National Academy of Sciences, and Secretariat for Scientific and Technical Research, Government of Senegal, West Africa |
| 1980 | Africare Primary Health Care Planning Mission, Uganda, East Africa |
| 1980-1988 | Advisory Council, Defense for Children, Geneva |
| 1986 | Population Council Child Survival Planning Mission, Institute of Child Health, Lagos, Nigeria, West Africa |
| 1996 | Consultant, Child and Family Protection Center, Philippines General Hospital, Manila, Philippines |

Professional Society Involvement:

- | | |
|-----------|--|
| 1974- | American Academy of Pediatrics |
| 1975- | American Orthopsychiatric Association (<u>President</u> , 1991-92) |
| 1976-1980 | Task Force on Child Abuse, American Academy of Pediatrics |
| 1976-1995 | Society for Epidemiologic Research |
| 1978-1982 | Committee on Social Policy, Society for Research in Child Development |
| 1980- | Society for Pediatric Research |
| 1981-1995 | American College of Epidemiology |
| 1981-1984 | Board of Directors, American Orthopsychiatric Association |
| 1982-1985 | Committee on Child Abuse, Council on Scientific Affairs, American Medical Association |
| 1982-1988 | Executive Council, International Society for the Prevention of Child Abuse and Neglect |
| 1987-1991 | Committee for Ethical Conduct in Child Development Research, Society for Research in Child Development |
| 1987- | American Pediatric Society |
| 1989-1992 | Vice Chair, Committee on Family Violence, American Medical Association |
| 1993- | Committee on Violence, Massachusetts Medical Society |

Community Service Related to Professional Work:

- | | |
|-----------|---|
| 1971-1979 | Board of Directors, Parents' and Children's Services, Boston |
| 1973-1984 | Community Advisory Council, Junior League of Boston |
| 1975-1980 | Board of Directors, Brookline Mental Health Association |
| 1975-1990 | Advisory Board, Museum of the National Center for Afro-American Artists, Massachusetts Committee for Children and Youth (<u>President</u> , 1978-1997) |
| 1977- | Pediatric Consultant, Gilday (Mission Hill) Child Care Center |
| 1980- | Board of Overseers, Massachusetts Cultural Education Collaborative |
| 1983-1986 | Committee on Infant Mortality, The Medical Foundation and Boston Department of Health and Hospitals |
| 1984-1986 | Advisory Board, Boston Institute for the Development of Infants and Parents |
| 1985-1994 | Committee on Health Delivery (Noonan Memorial Fund Grantee Selection Committee), The Medical Foundation, Boston |
| 1986-1995 | Board of Overseers, Planned Parenthood League of Massachusetts |
| 1992- | Board of Overseers, New England Conservatory of Music |
| 1994- | Board of Directors, Boston Music Education Collaborative |
| 1996- | |

Eli H. Newberger
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Editorial Boards:

1963-1966	Editorial Board, Yale Journal of Biology and Medicine
1977-1985	Editorial Board, Child Abuse and Neglect
1977-1978	Board of Consulting Editors, Monographs of the Society for Research in Child Development
1984-1990	Editorial Board, Victimology
1985-1998	Editorial Board, Journal of Interpersonal Violence
1985-	Editorial Board, Violence and Victims
1985-1989	Editorial Board, American Journal of Orthopsychiatry
1987-1990	Editorial Board, Book Series, Division of Child, Youth, and Family Services, American Psychological Association and University of Nebraska Press
1990-	Board of Governors, Family Violence Update
1990-1993	Editorial Board, Journal of Child Sexual Abuse
1992-	Editorial Board, Crisis Intervention and Time-Limited Treatment

Awards and Honors:

1965	Alpha Omega Alpha medical honorary society
1969-1972	Fellow, Career Development Program in Global Community Health, U.S. Public Health Service
1976	Annual Award for improvement of the welfare of children, Massachusetts Society for the Prevention of Cruelty to Children
1985	Helenka Adamowska Pantaleoni Award for the outstanding contribution to the betterment and welfare of children, Greater Boston Committee for UNICEF
1985	Commissioner's Award for outstanding contributions in the prevention of child abuse and neglect, U.S. Department of Health and Human Services, Administration for Children, Youth and Families
1988	Humanitarian Award, Massachusetts Psychological Association
1992	Award for Excellence for outstanding research in the infant-parent field, Boston Institute for the Development of Infants and Parents
1992	Community Achievement Award for outstanding efforts on behalf of abused children, B'nai B'rith Women of Massachusetts and the North East Region
1998	Gift of Safety Lifetime Achievement Award for Violence Prevention The LiveSafe Foundation (Impact Model Mugging)

Narrative Report of Clinical Practice:

After an internship in internal medicine, I spent two years in West Africa as a Peace Corps Physician. In this period, my interests developed in pediatrics and in epidemiologic approaches to understanding family and social concomitants of adult and child health. I began in 1969 a three-year course of study in which I completed a residency in pediatrics and a master's degree in epidemiology. During this training, I became deeply involved in efforts to address the problem of child abuse, and I organized in 1970 the Children's Hospital's first child abuse consultation unit. Also in this period, I conceived the notion of an interdisciplinary research and clinical unit on family violence and in 1972 organized, with support from the federal Office of Child Development, the Family Development Study.

This project housed an epidemiologic study of pediatric social illness (child abuse, childhood injuries, failure to thrive, and childhood ingestions), a child abuse consultation team, a clinic (Family Development Clinic) in the Hospital's outpatient department, and a family advocacy program. Staffed by an interdisciplinary group of

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Eli H. Newberger
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Narrative Report of Clinical Practice, continued

researchers and clinicians, it provided the setting from which to develop a number of research efforts and an institutional context in which could be explored and evaluated promising new clinical approaches in the family violence field. These include the AWAKE (Advocacy for Women and Children in Emergencies) Program which began in 1986. The first battered women's advocacy project at a pediatric hospital, AWAKE was conceived by a group of fellows and clinicians working in Family Development Clinic who had begun systematically to ask mothers of children referred for child abuse, child sexual abuse, and parental bonding assessments by family and juvenile courts, social welfare agencies, and medical and mental health personnel, about their current personal experiences with victimization. Under my guidance and with the consultation of local and national experts on programs for battered women, an intervention project was conceived which constructed a link with the battered women's service community. I continue to serve as the Director of the Family Development Program and as the Medical Director of the Child Protection Team and the Family Development Clinic at Children's Hospital.

Short Report of Research That Contributes to Care of Patients:

My research has pushed the family violence field forward in many theoretical and practical areas, drawing attention in the 1970's to the confining nature of the prevailing psychopathological conceptions on the etiology of child abuse and to the greater utility of an investigative and clinical perspective focusing on family and social stresses; conducting the first systematic evaluation of interdisciplinary practice on child abuse; proposing and demonstrating in my research and clinical work the value of the so-called "ecological" approach to understanding child abuse and related problems of parents and children; identifying and documenting the connection between child abuse and woman abuse and stimulating the design of the above-noted AWAKE Program; examining the effectiveness of family violence interventions and the impacts of family violence on the health care system; and applying a life-span developmental analysis to the impacts of family violence.

1. Current research project:

Character Development in Males: This is a two-year program to assemble material for a book, The Men They Will Become, that will summarize existing knowledge and provide representative examples of what parents and others can do to strengthen the characters of boys and to prevent the development of violent and antisocial behavior, with a particular focus on the abuse of women. The project involves literature review and analysis, drawing from sources in biology, pediatrics, psychology, psychiatry, anthropology, and sociology; interviewing parents, children, and professionals; and writing and editing. The book will be published in 1999.

2. Research funding information

<u>Years covered</u>	<u>Funding Source</u>	<u>Leadership Role</u>	<u>Grant Title</u>
1972-1977	U.S. Children's Bureau	Principal Investigator	Study of Social Illness in Children
1979-1997	N.I.H.	Principal Investigator	Clinical Research Training on Family Violence
1982-1985	Childhelp U.S.A.	Co-Principal Inv.	Impact of Child Physical Abuse
1985-1990	U.S. Children's Bureau, National Institute of Justice W.T. Grant Foundation\	Co-Principal Inv.	Victim Recovery Study
1989-1990	Deborah Monroe Noonan Fund The Medical Foundation	Principal Inv.	Pregnant Woman Abuse and Adverse Birth Outcome
1992-1994	Robert Wood Johnson Foundation	Co-Principal Investigator	Health Care and Family Violence Field Project

Teaching Contributions and their Relationship to Clinical Practice:

1972-	Attending Physician, Children's Hospital; inpatient and outpatient teaching and clinical supervision of Harvard Medical School students and Children's Hospital interns and residents, and pediatric residents of Massachusetts General, on child abuse and neglect and family violence. This teaching includes grand rounds on all the specialty services at Children's Hospital on a recurring basis to update the junior and senior staffs on recent advances in the field.
1972-74 1979-97	Section Leader, Department of Epidemiology, Harvard School of Public Health Director, Clinical Research Training Program on Family Violence, Children's Hospital
1981-95	Director, Annual conferences on abuse and victimization in life-span perspective, Department of Continuing Education, Harvard Medical School
1987-89	Tutor, Oliver Wendell Holmes Society (New Pathway Program), Harvard Medical School
1994-present	Course on Social Services for Children and Families, Department of Maternal and Child Health, Harvard School of Public Health

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1. Newberger EH, Hagenbuch JJ, Ebeling NB, Colligan EP, Sheehan JS, McVeigh SH. Reducing the literal and human cost of child abuse: impact of a new hospital management system. *Pediatrics* 1973; 51:840-848.
2. Newberger EH, Newberger CM, Richmond JB. Child health in America: toward a rational public policy. *Milbank Memorial Fund Quart/Health and Society*. 1976; 54:249-298; reprinted in: McKinley JD, ed. *Issues in health care policy*. Cambridge: MIT Press, 1981; 97-146.
3. Newberger EH, Reed RB, Daniel JH, Hyde JN, Kotelchuck M. Pediatric social illness: toward an etiologic classification. *Pediatrics*. 1977; 60: 178-185; reprinted in Cook JV, Bowles RG, eds. *Child abuse: commission and omission*. Toronto: Butterworths, 1980; 351-362.
4. Bourne R, Newberger EH. 'Family autonomy' or 'coercive intervention'? ambiguity and conflict in the proposed standards for child abuse and neglect. *Boston Univ Law Rev* 1977; 670-706.
5. Morse AN, Hyde JN, Newberger EH, Reed RB. Environmental correlates of pediatric social illness: preventive implications of an advocacy approach. *Am J Public Health* 1977; 67:612-615.
6. Daniel JH, Newberger EH, Kotelchuck M, Reed RB. Child abuse screening: implications of the limited predictive power of child abuse discriminants in a controlled family study of pediatric social illness. *Child Abuse Neglect* 1978; 2:247-259.
7. Newberger EH, Bourne R. The medicalization and legalization of child abuse. *Am J Orthopsychiatry* 1978; 48:593-607; reprinted in Eekelaar JM, Katz SN, eds. *Family violence*. Toronto: Butterworths, 1978: 301-317; in *Familien dynamic* (Zurich), 1979; in Cook JV, Bowles RT, eds. *Child abuse: commission and omission*. Toronto: Butterworths; 1979: 377-393; in Garland R, ed. *Readings in child abuse*. Guilford (Conn): Special Learning Corporation, 1979: 183-190; and in Skolnick JH, Skolnick A, eds. *Family in transition*. 3rd ed. Boston: Little, Brown, 1980: 411-426.

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Eli H. Newberger

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8. Resenfeld AA, Newberger EH. Compassion vs. control: conceptual and practical pitfalls in the broadened definition of child abuse. JAMA 1977; 237: 2086-2088; reprinted in Chess S, Thomas A, eds. Annual progress in child psychiatry and child development, 1978. New York: Brunner/Mazel, 1979; and in Am J Forensic Psychiatry, 1:71-81, 1979.
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10. Bourne R, Newberger EH. Interdisciplinary group process in the hospital management of child abuse. Child Abuse Neglect 1980; 4:137-144.
11. Kotelchuck M, Newberger EH. Failure to thrive: a controlled study of familial characteristics. J Amer Acad Child Psych 1983; 22:322-328.
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16. Bithoney WG, Snyder JC, Michalek J, Newberger EH. Childhood ingestions as symptoms of family distress. Am J Dis Child 1985; 139:456-459.
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18. Snyder JC, Newberger EH. Consensus and differences among hospital professionals in evaluating child maltreatment. Violence and Victims 1986; 1:125-139.
19. Newberger EH, Hampton R, White KM, Marx T. Child abuse and pediatric social illness: an epidemiological analysis and ecological reformulation. Am J Orthopsychiatry 1986; 56:589-601.
20. Bithoney WG, Newberger EH. Child and family attributes of failure to thrive. J Devel Behav Peds 1987; 8:32-36.
21. Dubowitz H, Hampton RL, Bithoney WG, Newberger EH. Inflicted and non-inflicted injuries: differences in child and familial characteristics. Am J Orthopsychiatry 1987; 57:525-535.

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22. Woolf A, Taylor L, Melnicoe L, Andolsek K, Dubowitz H, DeVos E, Newberger EH. What residents know about child abuse: implications of a survey of knowledge and attitudes. *Am J Dis Child* 1988; 142:668-672.
23. McKibben L, Devos E, Newberger EH. Victimization of mothers of abused children: a controlled study. *Pediatrics* 1989; 84:531-535.
24. Dubowitz H, Zuckerman DM, Bithoney WG, Newberger EH. Child abuse and failure to thrive: individual, familial, and environmental characteristics. *Violence and Victims* 1989; 4:191-201.
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26. Newberger CM, Gremy I, Waternaux CM, Newberger EH. Mothers of sexually abused children: trauma and repair in longitudinal perspective. *Am J Orthopsychiatry* 1993; 63:92-102
27. Cohen C, DeVos E, Newberger E. Barriers to Physician Identification and Treatment of Family Violence: Lessons from Five Communities. *Acad Med* 1997; 72: 19-25.

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1. Newberger EH. Book review of Violence against children (Gil DG). *Pediatrics* 1971; 48:668-670.
2. Newberger EH, Hagenbuch JJ. Book review of Helping the battered child and his family (Kempe CH, Helfer RD, eds.). *Pediatrics* 1973; 6:894.
3. Newberger EH. Book review of The maltreated child (Fontana V). *Pediatrics* 1973; 52:159
4. Newberger EH, Mulford RM, Hass G. Child abuse in Massachusetts, Massachusetts Physician 1973; 32:31-38
5. Newberger EH. The myth of the battered child syndrome. *Current Medical Dialog*. 1973; 40:327-330; reprinted in : Chess S, Thomas A, eds. Annual progress in child psychiatry and child development, 1974. New York: Brunner, Mazel, 1975; 569-573.
6. Newberger EH, Howard RB. A conceptual approach to the child with exceptional nutritional requirements. *Clin Pediatric* 1973; 12:456-467
7. Newberger EH. Child abuse and neglect. In: Graef JW, Cone TE, eds. Manual of pediatric therapeutics. Boston: Little, Brown, 1974, 56-58; 2nd Ed., 1980, 57-59.
8. Newberger EH, Hyde JN. Child abuse: principles and implications of current pediatric practice. *Ped Clin N Amer* 1975; 22:695-715; reprinted in: Gil D, ed. Child abuse and violence. New York: AMS Press, 1976:309-339.

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9. Newberger EH, Daniel JH. Knowledge and epidemiology of child abuse: a critical review of concepts. *Pediatr Ann* 1976; 5:140-145.
10. Newberger EH. A physician's perspective on the interdisciplinary management of child abuse. In: Ebeling NB, Hill DA, eds. *Child abuse: intervention and treatment*. Littleton: Publishing Sciences Group, 1975, 61-67; reprinted in *Psychiatr Opin* 1976; 13:13-18.
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14. Newberger EH. Child abuse and neglect: toward a firmer foundation for practice and policy. *Am J Orthopsychiatry* 1977; 47:374-376; reprinted in Cook JV, Bowles RT, eds. *Butterworths*, 1979; 363-365.
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25. Newberger EH. When the injury is a symptom: parental risk and child abuse. In: Hoekelman RA, ed. *Minimizing high-risk parenting*. Media (Pa.): Harwal, 1983; 165-174.
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87-458

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

May 3, 1988

Eli Newberger, M.D.

REDACTED COPY

RE: Complaint lodged against you by

Dear Dr. Newberger:

Following a thorough investigation of the complaint filed against you by the Board's Complaint Committee has decided to dismiss the complaint.

As you know, the Board is obligated to investigate complaints relating to the proper practice of medicine. Following a thorough review of the evidence gathered in this investigation, the Complaint Committee made the determination that no further action is warranted.

Thank you very much for your cooperation in this matter. If you have any questions, please do not hesitate to contact me at 727-1788.

Sincerely,

Carolyn Hartmann
Investigator

Members of the Board:

Marian J. Ego, J.D., Ed.D.
Vice Chairman
Marianne N. Prout, M.D.
Secretary

Ralph A. Deterling, Jr., M.D.
Physician Member
Louise Liang, M.D.
Physician Member

Melinda Milberg, Esq.
Public Member
Dinesh Patel, M.D.
Physician Member



Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

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

March 9, 1988

Eli H. Newberger

Dear Dr. Newberger:

The Board of Registration in Medicine has received the enclosed letter from .

The Board is obligated to investigate matters relating to the proper practice of medicine. In compliance with this mandate, the Board seeks all information pertaining to a complaint or inquiry. This investigation enables the Board to make a preliminary determination as to whether a matter warrants further action.

In order to allow us to fully understand the circumstances surrounding the enclosed letter, the Board kindly requests that you respond to the enclosed by addressing the substantive issues set forth in the letter. Specifically, please respond to the allegations that you were negligent in failing to consider the evidence of child abuse in your evaluation of . Please be advised that 243 CMR 2.07 (12) requires that you respond within thirty (30) days' receipt of this letter.

Thank you very much for your prompt attention to this matter. Please direct your response and any questions to my attention.

Sincerely,

Carolyn Hartmann

Carolyn Hartmann
Investigator

CH/cd

CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Members of the Board:

Marian J. Ego, J.D., Ed.D.
Vice Chairman

Marianne N. Prout, M.D.
Secretary

Ralph A. Deterling, Jr., M.D.
Physician Member

Louise Liang, M.D.
Physician Member

Melinda Milberg, Esq.
Public Member

Dinesh Patel, M.D.
Physician Member



The Children's Hospital • Boston

300 Longwood Avenue, Boston, Massachusetts 02115 • (617) 735-6000

March 21, 1988

POOR ORIGINAL COPY

Ms. Carolyn Hartmann
Investigator
Board of Registration and Medicine
Ten West Street
Boston, MA 02111

Dear Ms. Hartmann:

In response to your letter of March 9, I have reviewed the photocopied letter from _____ of _____, Massachusetts, dated October 14, 1987, pertaining to a child named _____ known to the Children's Hospital as _____. I have also reviewed the patient's clinic records.

_____ granddaughter
(DOB _____) was seen by me in Family Development Clinic on November 2, 1973 and on April 25 and May 6, 1974. The records indicate that at these times my colleagues and I conducted an assessment of the child. These assessments included physical examination and psychological study.

The evaluation reports and my independent recollection indicate that the examinations failed to reveal artifacts of child abuse in the patient. At the request of the Suffolk Probate Court, I later testified about our evaluation and diagnostic impressions.

I would like to assure you that I take very seriously my responsibility to fulfill the mandate to report cases of suspected abuse and neglect. At the time this child was seen in consultation, I served as the hospital's senior

POOR ORIGINAL COPY

Page 2

pediatrician on the child abuse consultation unit. I did not make a case report of child abuse in this instance because the case facts did not fulfill the statutory standard for reporting.

If there is further information I can provide, please do not hesitate to contact me.

Sincerely,

E. H. Newberger M.D.

Eli H. Newberger, M.D.
Director
Family Development Study

EHN:ysf

POOR ORIGINAL COPY

SEP 14 1957

Mr Mary ~~Hans~~ Kelly

Registration of Medicine Re Case 872

10 West St

Boston Mass 02111

Dear Mr ~~Hans~~ Kelly

Would appreciate it if you would
make a thorough investigation of this
case.

Not only is Dr Alan Marks involved
in this case but Dr Eli Newberger
and Dr Leonard Friedman. (Name omitted)

If Dr. Marks had followed the

2) usual procedure he would have asked for release of any previous evaluation and checked into

Medical and Psychiatric records. If that had been done he would have known how serious the situation was.

An evaluation ^(Carroll Ann) done by " " ?

-- Come ^{dated} April 18, 1977 was never brought into court. It was done at the insistence of who represented

- and Atty who was supposed to be representing my daughter. Incidentally Atty, one of my friends

was ~~attained~~ in July 1980

(3)

claimed he could not get a court date from March 1976 to July 1977 when my daughter died -
 mind him. (He was disbarred in July 1980)

My daughter spoke to Dr. Newberger over the telephone and also brought her to the Children's Hospital with proof of child abuse. He did nothing about it, and to our knowledge there is no record of the examinations.

Since Dr. Newberger visited the same day and I have no idea what he was told or shown.

The enclosed letter will explain

Dr. [unclear] part in this
radical situation.

had represented himself as a
Marriage Counselor.

Because my daughter's attorney
couldn't get the case out of the Suffolk
Court and had no money she was at
the mercy of [unclear] and his
attorney.

I filed for Grandparents Rights.

As we know now and as [unclear] 102

McLennan [unclear]

stated in Court under oath.

has a "Deep emotional problem"
It was based on [unclear] - [unclear] record at the [unclear]
Against Dr. [unclear] recommendation

5, 2, 11. Took Christine back to
Dr Eli Newberger and ^{was} in
therapy there. I'm not sure how
long she was there. (Children Hospital)

After my suggestion because of
my persistence ^{she} was evaluated
by a Mr ^{Dr} ^{at} a Clinical Social
worker. ^(McLean Hospital) All information in the assess-
ment to the court furnished by Mr
^{previous record was ignored.}
is now ^{you} old and
there is nothing we can do. She
has been thoroughly brain washed, no
one can help her.

(6) ^{Kelly} ~~Mr. Hadd~~ this is a poor story
and all caused by the very
people who should have protected
Christine and helped her.

Edentic is
aproud for what he is as I
stated years ago he will continue
to manipulate people and destroy
anyone who is a threat to him.

I'm not able to continue any
longer, As my Doctor said "my heart
can't take it" but I cannot see a
child destroyed. She is not alone, a victim
of "Psychological abuse". Sincerely,

does not
a clean bill of health



Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

An Agency within the Office of Consumer Affairs and Business Regulation

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

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DOROTHY KEVILLE, M.Ed

ROSCOE TRIMMIER, Esq.

REGIS DE SILVA, M.D.

REDACTED COPY

July 13, 2001

John J. Reardon
Hassan & Reardon
535 Boylston Street
Boston, MA 02116

Re: :/Eli Newberger, M.D.
Docket Number: 99-085

POOR ORIGINAL COPY

Dear Mr. Reardon:

The Complaint Committee of the Board met on June 27, 2001, and carefully considered the above referenced complaint. The members determined that no further action is warranted. The complaint has been dismissed.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort that you expended in preparing your response. If you have any questions, please call me at 617-727-1788, or write to me at the above address.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager





Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

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DOROTHY KEVILLE, M.Ed

ROSCOE TRIMMIER, Esq.

REGIS DE SILVA, M.D.

July 13, 2001

POOR ORIGINAL COPY

Re: Eli Newberger, M.D.
Docket Number: 99-085

Dear :

The Complaint Committee of the Board of Registration in Medicine met on June 27, 2001, and carefully considered the information you furnished it regarding your complaint against the physician referenced above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues you raised.

After a thorough review of this evidence, the Committee determined that your complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions, I can be reached at the number or address listed above.

Thank you again for your concern.

Very truly yours,

Kathleen M. Shea

Consumer Protection Manager

October 12, 1999

Consumer Protection Coordinator
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Re: Eli H. Newberger, M.D.
Docket No. 99-085

Dear Sir/Madam:

This letter responds to the Board of Registration's letter dated March 10, 1999. I received my Bachelor of Arts degree in 1962 from Yale College, my M.D. in 1966 from Yale School of Medicine and my M.S. degree in 1972 from Harvard School of Public Health. I was an Intern at Yale-New Haven Hospital from 1966 to 1967. I then spent two years in West Africa as a Peace Corps Physician. In 1969 I began a three-year course of study in which I completed my residency in pediatrics at Children's Hospital in Boston and a master's degree in epidemiology. During this training, I became deeply involved in efforts to address the problem of child abuse, and in 1970 I organized the first child abuse consultation unit at Children's Hospital. Also in this period, I conceived the notion of an interdisciplinary research and clinical unit on family violence and in 1972 organized the Family Development Study. I continue to serve as the Director of the Family Development Program and as the Medical Director of the Child Protection Team and the Family Development Clinic at Children's Hospital. I have conducted hundreds of similar investigations into allegations of sexual abuse against children in my career. This is the first time the team or myself has ever received a complaint regarding our evaluation. Please see my curriculum vitae for further information regarding my professional background.

The Family Development Program is a multidisciplinary medical program that receives referrals for physical abuse, sexual abuse, and family violence from physicians, other health professionals, social service agencies, the legal system, and other hospitals. These cases are complex and often involve extensive legal contacts and complete family evaluations, including psychological testing and psychiatric evaluations. The Program utilizes a multidisciplinary approach in order to obtain different perspectives on a case by drawing on the experience and knowledge from many different fields of study. This approach leads to a more comprehensive formulation and recommendation and reduces the risk for individual bias. The focus of the team during an evaluation is the well being of the children at the present time.

The family, (The parents and and the two children 7 years old, and 3 years old), were initially referred to the Family Development Program by Brockton Child and Youth Services due to concerns about sexual abuse of by had disclosed to her mother, her and the that her father "had put a pink thing in her private" while she was

in the bathtub and that he had asked her to "kiss his pee-pee". During the course of the investigation, [redacted] made additional disclosures to a DARE police officer at her school that her father touched her "privates". [redacted] subsequently made disclosures to his teacher that his father touched his penis and [redacted] acted out oral-genital contact between him and his father. A 51-A was filed by the [redacted] at [redacted] and a [redacted] investigation occurred concurrently with this evaluation.

The practice of the Family Development Program is to convene a team appropriate to the needs of the case at the time of a referral. The Program functions in a team concept whereby decisions on a particular case are reached by all team members assigned to a case. The team generally meets once or twice a week to discuss an ongoing case and to keep the other team members updated on what they have uncovered.

In the [redacted] case, the team consisted of two pediatricians, (myself and a post doctoral fellow [redacted]), a psychologist, ([redacted]), and a social worker, ([redacted]). The [redacted] family was evaluated by this team from approximately October 3, 1996 to April 1, 1997. The purpose of these evaluations was to determine the veracity of the allegations of abuse of the children through such means as interviewing the family members and contacting outside professionals familiar with the family to get multiple points of reference and to corroborate information obtained during the interviews. When the team encountered conflicting information from collateral sources, the team would then investigate the conflicting information. In the [redacted] case, the team did not uncover any conflicting information from any collateral sources. In fact, the collateral sources contacted all corroborated the disclosures and information obtained by the team through the interviews of the [redacted] family, with the exception of [redacted]. In comparison, [redacted] version of events diverged markedly from the reports the team received from the collateral sources the team contacted.

My role in this case was to observe my colleague's interviews of the children and of the mother, [redacted] and to supervise the process whereby our impressions were collected, opinions formulated, and the report is written. Additionally it was my duty to interview [redacted] as part of the team's investigation. As for the other team members, [redacted] interviewed [redacted], interviewed [redacted] and [redacted] interviewed [redacted]. The team also observed [redacted] interact with [redacted] and [redacted] individually to obtain information about the quality of the maternal-child relationship and to see if any concerns arose as an outgrowth of the observations. The team decided not to conduct observation sessions between [redacted] and either of the children as it was felt that, given the children's current symptomology, even a supervised visit with their father might cause undue risk of psychological harm. Additionally, the team contacted [redacted] therapist [redacted] school principal [redacted] schools psychologist [redacted] Head Start School Family Advocate [redacted] and [redacted].

A brief synopsis of these interviews is contained hereafter. However, because of confidentiality concerns regarding discussing our evaluation with third parties, I have not included any information in my response that was not previously released to the family during their court proceedings. I have not included a copy of the Family Development Program's report on the family because of the confidential nature of the report but I believe the report is available from the parties directly.

Furthermore, I was provided by the BRM a copy of a release to discuss the children's medical records and care with the BRM which was executed by the children's father, on February 17, 1999, a copy of which is attached hereto. To date, I am not aware of a release executed by to discuss her care and/or evaluation. Therefore, I have limited my discussion of the evaluation of the family to and the children as allowed for by the release provided to me by the BRM.

In accordance with the request by Brockton Child and Youth Services for a full family evaluation, was interviewed by on 10/3/96, 10/17/96, 10/31/96, and 11/7/96. The first two interviews were conducted with in attendance while the remaining two interviews were observed by members of the Family Development team including and myself. Since has not executed a release of her medical records and information I am unable discuss the details of her interviews.

was interviewed by on 10/31/96, 2/6/97, and 3/6/97. I recall observing all three of these interviews. It was the team's impression that seemed highly anxious, hypervigilant, aggressive and agitated during her evaluations. was unable to answer questions and stay in the evaluation room for any length of time. She screamed, tested limits, was aggressive towards the evaluator and touched the evaluator inappropriately on one occasion. Her play involved themes of victimization, control and aggression. It was the team's conclusion that presentation was consistent with that of a child who has been severely traumatized. In addition, was quite clear that she did not feel safe with her father and her behavior and statements indicated that she was very angry with him.

The team also contacted therapist, who informed the team that had disclosed seeing her mother handcuffed and raped and that has acted this out with dollhouse figures. also talked a great deal about "daddy hitting mommy" and about her and her father having "special secrets" and about daddy being "bad". n also stated that had been displaying a great deal of sexualized behavior in the sessions including frequent masturbation. The team also contacted school principal informed the team that had been a management problem at the school and had engaged in a great deal of hitting, pushing and touching other children. added that there had been a profound change in her behavior and that he found to be "open, cooperative and communicative". The team also contacted reported that while at a DARE class at

school relating to good/bad touch disclosed to him that her father touches her in private places. went on to say that had also been saying this to various teachers at the school. The team also contacted school psychologist reported that began the school year with many behavior problems including pushing and shoving other children, tantrumming, being totally defiant, and frequently masturbating. When contacted approximately 3 months later, stated that has improved since the beginning of the year and is not acting out as much. also stated that has said "My daddy touches me in bad places" multiple times. has also told about seeing her mother tied up and raped. The team also contacted regarding stated that she did not say anything to the investigator during the 51A investigation but later told her "Yuck, all he () does is bad touches, not good touches."

was interviewed by on 11/14/96, 11/21/96, 12/12/96, and 4/3/97. I recall observing these interviews. It was the team's impression that throughout his interviews appeared to be agitated, hypervigilant, and aggressive in a way that was consistent with tremendous anxiety and upheaval. His play involved themes of physical violence and his conversation was very disjointed. He was notably avoidant of the anatomical dolls and did not want to answer questions about them. During the final interview disclosed that his father "did something" to his penis but refused to discuss the matter further. The team considered the possibility that could have heard a remark like this from another person and concluded that behavior and emotional responses were more consistent with trauma than coaching, including his marked reluctance to engage with the dolls.

The team also contacted to obtain information regarding informed the team that had made two previous comments regarding his father to teachers at the school that were documented. On January 14, 1997, told a teacher that he would "crack his daddy in the head". The teacher asked why he would do that to his daddy and responded "cause he" and then mimicked an open mouth like a fish and continued to say "to my penis". The teacher took to the Family advocate's office and although he refused to speak, shook his head yes when asked if the teacher repeated what had told her. On January 22, 1997, a teacher overheard telling friends at breakfast that "my dad did something bad to me and my sister when we went to Maine". The team also contacted the DSS worker regarding the 51A report filed on behalf of for sexual abuse with an unknown perpetrator. stated that the reason the report was filed with an unknown perpetrator was because named both his father and another man as perpetrators. (Of note, at no time did DSS inform the Children's team of the possible identity of this unknown perpetrator.) The team also contacted therapist who informed the team that had stated to her that "Daddy put his mouth on my penis" and "Daddy is bad" but did not want to talk further about these statements.

was interviewed by myself on 10/11/96 and 12/19/96. interviews were characterized by a lack of serious discussion of the allegations against him or of the children's behavior problems. He possessed a tremendously negative view of and displayed a lack of personal responsibility for some of the marital and family problems. His mood would swing in the course of an interview from quiet to very intense. It was the team's impression that was a less credible reporter of events because of his negative perception of the children's mother and his inability to accept responsibility for his own contributions to the disturbance of the family.

version of events diverged markedly from the reports the team received from collateral sources. For example, police reports of complaints of domestic violence appeared to contradict version that he did not harm his intimates. Furthermore, disclosures of abuse by against corroborated version of abuse by denials and accusations were not corroborated by any collateral source and therefore deemed less accurate.

At all times the team was acting with the best interests and continuing safety of the children as our primary goal. In connection with the team's evaluation, I did an appropriate examination and review of the family in connection with the purpose of the evaluation. allegations that I disregarded the truth and placed and in jeopardy are without merit. The purpose of our investigation was to determine the veracity of the allegations of sexual abuse of initially and later by Our conclusions were based upon the coherence of the information gathered during our clinical interviews of both children and both parents, the collateral reports of the children's , the , the and All reports with the exception of and his current partner, corresponded to the conclusion that sexually offended against his children and abused his wife. The children's presentation in the clinic was alarming as they both appeared hypervigilant and agitated. This kind of anxiety is not consistent with coaching of a child and adds support to the collateral reports. The team unanimously reached their conclusion regarding

It is important to point out that the team's report was only a recommendation and the final decision was with the Court. allegations that I allowed the children to live in a dangerous situation are without merit. The ultimate decision on whom the children were allowed to live with was made by the Court during the custody dispute between the parents. The purpose of the team's evaluation was solely to determine the veracity of the sexual abuse claims against allegation that the team ignored information regarding is not accurate. As is aware and has referred to in numerous letters to Children's Hospital and other individuals, the DSS never informed the Children's Hospital team of ' history of offending behavior nor the possibility that may have been the "other" perpetrator of sexual abuse named in the 51A filed on behalf of The was conducting its own investigation into as a possible offender.

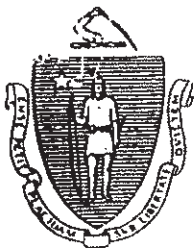
I believe my team conducted a fair evaluation of the family and at all times was acting with the future safety of the children as our primary focus. Our recommendation that have no contact with his children for the present time was based on what the team believed was in the best interests of the children.

If needed, I welcome an informal conference before the Complaint Committee. Please advise me when such a conference is scheduled. Due to the confidentiality issues addressed above, certain information has been withheld from our response. If you require this information or any additional information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in cursive script, appearing to read "Eli Newberger, M.D.", written in dark ink.

Eli Newberger, M.D.



Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

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

Rec'd
2/22/99

ALEXANDER F. FLEMING, J.D.
EXECUTIVE DIRECTOR

PENELOPE WELLS, J.D.
GENERAL COUNSEL

COMPLAINT FORM **POOR ORIGINAL COPY**

Please type or print clearly, and provide all of the information requested.

<input type="checkbox"/> Mrs. Your First Name	Last Name	Patient Name (if different)
<input type="checkbox"/> Ms.		
<input checked="" type="checkbox"/> Mr.		
Street Address		Mailing Address (if different)
City		State
		Zip Code
Business/Daytime Phone		Home Phone

Complaint against M.D. ☒ , D.O. ☐ , Acupuncturist ☐ . (For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 100 Cambridge St., Boston, MA 02202.) This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.

Dr. Eli Newburger		
Address		
300 Longwood Ave		
City	State	Zip Code
Boston	MA	02115
Business Phone		
617-355-6000		
Name and Location of Health Care Facility (if known)		
Boston Children's Hospital		

Nature of Complaint

- | | |
|--|---|
| <input checked="" type="checkbox"/> Substandard Medical Care | <input type="checkbox"/> Drug Dealing |
| <input checked="" type="checkbox"/> Professional Misconduct | <input type="checkbox"/> Criminal Conviction |
| <input type="checkbox"/> Sexual Misconduct | <input checked="" type="checkbox"/> Patient Neglect/Abandonment |
| <input type="checkbox"/> Rude or Discourteous Behavior | <input checked="" type="checkbox"/> Unlawful Discrimination |
| <input type="checkbox"/> Impaired by Alcohol or Drugs | <input type="checkbox"/> Billing for Services Not Rendered |
| <input type="checkbox"/> Impaired by Mental or Emotional Illness | <input type="checkbox"/> Failure to Supervise Staff |
| <input type="checkbox"/> Failure to Provide Medical Records | <input type="checkbox"/> False Advertising |
| <input type="checkbox"/> Overcharge for Medical Records | <input checked="" type="checkbox"/> Fraud |
| <input checked="" type="checkbox"/> Other <u>Child abuse</u> | |

Please do not write below this line.

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: 2.17.99
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT WITH AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233, § 20B.

Signature of Patient: _____ Date: 2.17.99
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

If you are not the patient, what is your relationship to the patient?

☐ Spouse, ☒ Parent, ☐ Child, ☐ Other Relative _____, ☐ Friend, ☐ Attorney, ☐ Other _____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)

☐ Yes, ☒ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?

☐ Yes, ☒ No

How long have you (or patient) been under this physician's care?

☐ 1 to 30 days, ☒ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.

☐ Commercial Insurance, ☐ Health Maintenance Organization, ☒ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other _____

Are you (or patient) expected to pay a portion of this bill out of pocket?

☐ Yes, ☒ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?

☐ Yes, ☒ No

Is the fee or copayment in dispute?

☐ Yes, ☒ No

Has the physician been contacted about this complaint?

☒ Yes, ☐ No

Dates of Treatment: Oct. 1996 - May 1997

POOR ORIGINAL COPY

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

See Attached Please
letters and supporting documents

Attach copies of related documents to this form.

The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: _____

Date: 2.17.99

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111

February 17, 1999

To: Consumer Protection Coordinator
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

From:

Dear Sir/Madam,

My complaints against Dr. Eli Newberger of Boston's Children's Hospital's and his child abuse team are as follows:

1. Dr. Newberger, and the child abuse team recklessly disregarded the truth and in doing so placed and in jeopardy. Due to Dr. Newberger and his teams sloppy assessment of the family, the children continue to live with a confessed child molester.
2. Dr. Newberger had information at his disposal that was contrary to his beliefs. Page six of the Children's Hospital's report of interviews (attached) state that she was/is romantically involved with my cousin, . Page 2 of the Children's Hospital's report (attached) states that DSS told the Children's Hospital of another man named by as a perpetrator. Dr. Newberger did no follow up on this information.
3. Page 97-100 of the deposition of Dr. Eli Newberger (attached, dated 8/20/97) indicate that he had know idea who was and that it was the first time he had knowledge that anyone else was named as a perpetrator. This is contrary to the his own report that he signed in May 1997. (attached)
4. His written record of the interviews between Dr. Newberger and myself and dated 10/11/96 and 12/19/96 are distorted views of the discussion we had with him. He also showed bias in only interviewing me two times while was interviewed four times alone and twice with the children.

I have enclosed all relevant portions of deposition on 4/23/98. I am sure once you review this information you will agree that this man should have been included in the family assessment at the Children's Hospital and seriously considered as a

perpetrator of sexual abuse on my children. I continue to assert my innocence as I have since this nightmare began.

 was dating and then subsequently moved in with a confessed child molester, at the same time the allegations of sexual abuse were instigated by her. The only person Dr. Newberger suspected and then confirmed as the sexual abuser of and was me. He never investigated the possibility that someone else perpetrated the abuse although he had ample reason to investigate further.

The Children's Hospital's assessment went from October 10, 1996 until May 1997. DSS finished their investigation in early April 1997. DSS relied heavily on Dr. Newberger and his team to make the final decisions on the children. DSS closed their case and indicated that they were leaving the outcome up to Children's Hospital. (document's headed with DSS Referral, Assessment Conclusion and Family Functioning attached).

Please Note: Although it is stated that the court order Children's to do an assessment, this is incorrect. hired Children's to do the assessment. Also I was not the instigator of any violence between us. has a volatile temper.

In short, the reports and depositions enclosed show that:

Dr. Newberger had information at his disposal that should have caused him to investigate , a confessed child molester living in the home with and

He was also told by that her own childhood was filled with physical, sexual and emotional abuse and that she was placed in 31 foster homes from age 12 until 18 years old. (see attached page 3 from Children's report) She never received therapy to help her through her childhood traumas until three months after she accused me of abusing the children. Dr. Newberger et al didn't question her credibility whatsoever, he stated she was a genuine concerned mother. (see attached page 6 of Children's report)

(see letters written by attached) and of New Hampshire had vital information to share with Dr. Newberger. He never contacted either of these people although their names and phone numbers were given to him. They were both involved with the children from February 1996 until June of 1996 when and the children lived with the in re.

 counseled and during those months. Both and testified that neither had been told nor had they witnessed any of the alleged acts that stated the children were exhibiting from April until June of 1996. statements were made at a restraining order hearing on July 26, 1996. She said that the children were swearing, masturbating, grabbing crotches, grabbing woman's breast and had bruises from the first overnight visit

with us on April 5, 1996. (Contempt hearing September 1996 in Maine, over 100 pages, transcript available upon request)

testified as an expert witness in the v. trial in April 1998 in Maine. A brief synopsis of her professional opinion is enclosed. (entitled

said that he and became romantically involved in April of 1996. says that they became romantically involved a month after (July) she moved into his home. (see attached deposition, page 6 and deposition page 13)

ignored a subpoena ordering him to produce records on his abuse of his daughter, (see attached deposition)

told that he stopped drinking alcohol after his DUI conviction in 1995. (see attached e and , page 17; paragraph 3) In deposition he said that he didn't stop drinking alcohol until December of 1997. (see attached page 15 of deposition)

was evasive about his prior acts of sexual abuse towards his daughter throughout the deposition and on the witness stand. He did in fact sexual abuse his daughter for three years from the time she was age one. (ex wife, confirmed this to my Maine attorney in November 1997) stated that he touched his daughter's pee pee. (attached deposition page 20)

th told that he has never been left alone with the children and yet in deposition he reports a one time incident where he was left alone with the children before the I investigation. (see attached deposition, page 28 and Parent Substitute in the Home page) Both and tell conflicting stories about s parental responsibilities towards the children. (see attached page of Interrogatories relevant to this and reports pages 17 and Parent Substitute in the Home)

Dr. Eli Newberger et al did my children a grave injustice. By neglecting to do a thorough assessment of all the parties involved with and he validated an angry, vengeful woman's accusations and he left two children in the hands of a child molester. Dr. Newberger told me after the 10/19/96 interview that he would schedule psychological evaluations for and myself. Those evaluations never materialized.

I left the marriage after 14 years of abuse at the hands of Dr. Newberger's assessment of as a battered woman is atrocious. For a Dr. with "25 years experience" he was fooled easily.

In Dr. Newberger's own words, "... children will sometimes say that others have offended against [them], and this is often in the context of threats or coercion's not to tell their stories." (page 100, Newberger's deposition) It would be impossible for me to threaten and/or coerce _____ and _____ given the fact that I have had no contact with them since July 5, 1996.

Due to Dr. Newberger's assessment, _____ and _____ (also known as _____) continue to live with _____. If you need more documents and/or information please feel free to contact me.

Sincerely,



Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568

An Agency within the Office of Consumer Affairs and Business Regulation

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

PETER N. MADRAS, M.D.
CHAIR

RAFIK ATTIA, M.D.

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MARTIN CRANE, M.D.

DOROTHY KEVILLE, M.Ed

ROSCOE TRIMMIE, Esq.

REGIS DE SILVA, M.D.

July 17, 2001

John J. Reardon
Hassan & Reardon
535 Boylston Street
Boston, MA 02116

REDACTED COPY


Re: Eli H. Newberger, M.D.
Docket Number: 99-160

Dear Mr. Reardon:

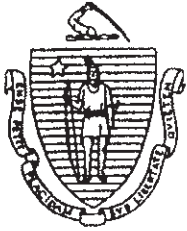
The Complaint Committee of the Board met on June 27, 2001, and carefully considered the above referenced complaint. The members determined that no further action is warranted. The complaint has been dismissed.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort that you expended in preparing your response. If you have any questions, please call me at 617-727-1788, or write to me at the above address.

Very truly yours,


Kathleen M. Shea
Consumer Protection Manager





Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

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ROSCOE TRIMMIER, Esq.

REGIS DE SILVA, M.D.

July 17, 2001

Re: Eli H. Newberger, M.D.
Docket Number: 99-160

Dear

The Complaint Committee of the Board of Registration in Medicine met on June 27, 2001, and carefully considered the information you furnished it regarding your complaint against the physician referenced above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues you raised.

After a thorough review of this evidence, the Committee determined that your complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions, I can be reached at the number or address listed above.

Thank you again for your concern.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager



October 12, 1999

Consumer Protection Coordinator
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Re: Eli H. Newberger, M.D.
Docket No. 99-160

Dear Sir/Madam:

This letter responds to the Board of Registration's letter dated April 22, 1999. I received my Bachelor of Arts degree in 1962 from Yale College, my M.D. in 1966 from Yale School of Medicine and my M.S. degree in 1972 from Harvard School of Public Health. I was an Intern at Yale-New Haven Hospital from 1966 to 1967. I then spent two years in West Africa as a Peace Corps Physician. In 1969 I began a three-year course of study in which I completed my residency in pediatrics at Children's Hospital in Boston and a master's degree in epidemiology. During this training, I became deeply involved in efforts to address the problem of child abuse, and in 1970 I organized the first child abuse consultation unit at Children's Hospital. Also in this period, I conceived the notion of an interdisciplinary research and clinical unit on family violence and in 1972 organized the Family Development Study. I continue to serve as the Director of the Family Development Program and as the Medical Director of the Child Protection Team and the Family Development Clinic at Children's Hospital. I have conducted hundreds of similar investigations into allegations of sexual abuse against children in my career. Please see my curriculum vitae for further information regarding my professional background.

The Family Development Program is a multidisciplinary medical program that receives referrals for physical abuse, sexual abuse, and family violence from physicians, other health professionals, social service agencies, the legal system, and other hospitals. These cases are complex and often involve extensive legal contacts and complete family evaluations, including psychological testing and psychiatric evaluations. The Program utilizes a multidisciplinary approach in order to obtain different perspectives on a case by drawing on the experience and knowledge from many different fields of study. This approach leads to a more comprehensive formulation and recommendation and reduces the risk for individual bias. The focus of the team during an evaluation is the well being of the children at the present time.

and their son , were initially referred to the Family Development Program in early 1992 while involved in a court proceeding in which the court suggested an agreement between the parties for a family assessment by an independent expert. The family had already been through a court ordered sexual abuse assessment of in May-June of 1988 and another court ordered report by a court investigator in July 1988. was ordered by

the Court in 1991 to provide an updated report to the Court and this updated report was submitted to the Court in January 1992.

The practice of the Family Development Program is to convene a team appropriate to the needs of the case at the time of a referral. The Program functions in a team concept whereby decisions on a particular case are reached by all team members assigned to a case. The team generally meets once or twice a week to discuss an ongoing case and to keep the other team members updated on what they have uncovered.

In the case, the team consisted of a licensed psychologist, (), a post-doctoral psychology fellow () and myself, a pediatrician and Chief of the Program. The family was evaluated by this team from approximately February 27, 1992 to May 8, 1992. The purpose of these evaluations was to determine the veracity of the allegations of abuse of by and evaluate the appropriateness of visitation between and .

This evaluation was accomplished through such means as interviewing the family members and contacting outside professionals familiar with the family to get multiple points of reference and to corroborate information obtained during the interviews. When the team encountered conflicting information from collateral sources, the team would then investigate the conflicting information. In the case, the team did not uncover any conflicting information from any collateral sources. In fact, the collateral sources reviewed all corroborated the disclosures and information obtained by the team through the interviews of the family.

My role in this case was to observe my colleague's interviews of the mother, interview the child and to supervise the process whereby our impressions were collected, opinions formulated, and the report is written. As for the other team members, interviewed and I interviewed the mother. The team decided not to conduct observation sessions between and as it was felt that, given the reports of previous expert evaluators and the child's current symptomology, even a supervised visit with the father might cause undue risk of psychological harm. Additionally, the team reviewed the voluminous professional records in this case including the court ordered evaluations by the evaluations by the New Bedford Child and Family Services, the court ordered sexual abuse assessment by M.S., parenting assessment by , clinical records of therapist) and therapist), and the records of various custody Court proceedings.

A brief synopsis of these interviews is contained hereafter. However, because of confidentiality concerns regarding discussing our evaluation with third parties, I have not included any information in my response that was not previously released to the family during their court proceedings. I have not included a copy of the Family Development Program's report on the family because of the confidential nature of the report but I believe the report is available from the directly.

Furthermore, I was provided by the BRM a copy of a release to discuss medical records and care with the BRM which was executed by the father on March 29, 1999, a copy of which is attached hereto. To date, I am not aware of a release executed by to discuss her care and/or evaluation. Therefore, I have limited my discussion of the evaluation of the family to and as allowed for by the release provided to me by the BRM.

was interviewed by and myself on 2/27/92, 3/5/92 and 5/7/92. Since has not executed a release of her medical records and information I am unable discuss the details of her interviews.

I interviewed on 2/27/92, 3/5/92 and 5/7/92. It was the team's impression that throughout his interviews indicated a high level of anxiety about the possibility of seeing his father and recounted in detail his fears of being victimized by his father. appeared anxious during these interviews and on many occasions expressed a worry that his father might track him down. On several occasions stated "No matter what the judge says, I am not going to see (his father)." also described nightmares including dreams that his father trying to kill him. also reported that he tries to stay up and keep from going to sleep because he is "too frightened".

interviewed on 3/19/92, 4/9/92 and 4/16/92. The purpose of these interviews was to focus on obtaining mental status and history information regarding allegations that abused interviews were characterized as very guarded, avoidant and defensive when responding to questions. The team felt that interest in and concern over his son was superficial and his perspective on relationships and his son's needs was characterized as narcissistic. seemed inclined to seek any and every professional opinion which might favor his side of what he felt was an argument about experience. This superficiality of his concern for gave the team concerns about the prospect of risk to if his father became responsible for his care. It was the teams opinion that was more concerned about his own rights and privileges than he was concerned about what was and is best for his son.

At all times the team was acting with the best interests and continuing safety of the child, as our primary goal. In connection with the team's evaluation, I did an appropriate examination and review of the family in connection with the purpose of the evaluation. allegations that I was intent on finding abuse where none existed and was overly and unprofessionally aggressive in reporting alleged abuse that never occurred are without merit. The purpose of our investigation was to determine the veracity of the allegations of abuse of by and evaluate the appropriateness of visitation between and Our conclusions were based upon the coherence of the information gathered during our clinical interviews of the child both parents, and the collateral reports of

previous court ordered evaluations and therapy. All reports with the exception of [redacted] corresponded to the conclusion that [redacted] suffered a psychological trauma involving [redacted] presentation in the clinic was alarming, as he appeared to suffer from post-traumatic distress disorder manifesting in nightmares, sleeplessness, and behavioral disturbances. This kind of behavior is not consistent with coaching of a child and adds support to the collateral reports. The team unanimously reached their conclusion regarding [redacted]. Further, it is important to point out that the team's report was only a recommendation and the final decision was with the Court.

I believe my team conducted a fair evaluation of the [redacted] family and at all times was acting with the future safety of the children as our primary focus. Our recommendation that [redacted] have no visitation with [redacted] for the present time was based on what the team believed was in the best interests of the child.

As you are aware, because of the confidentiality concerns I have been unable to respond to the Complaint as fully as I would like. Hopefully, the Board will determine that the team's evaluation and assessment were appropriate based upon the information I have provided in this response. However, if needed, I welcome an informal conference before the Complaint Committee. If you require additional information, please do not hesitate to contact me.

Sincerely,



Eli Newberger, M.D.



Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

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

ALEXANDER F. FLEMING, J.D.
EXECUTIVE DIRECTOR

PENELOPE WELLS, J.D.
GENERAL COUNSEL

COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

<input type="checkbox"/> Mrs.	Your First Name	Last Name	Patient Name (if different)
<input type="checkbox"/> Ms.			
<input checked="" type="checkbox"/> Mr.			
Street Address		Mailing Address (if different)	
City	State	Zip Code	
Business/Daytime Phone		Home Phone	

Complaint against M.D. ☒ D.O. ☐ Acupuncturist ☐ (For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 100 Cambridge St., Boston, MA 02202.) This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.		
Eli H. Newberger, M.D. Children's Hospital		
Address		
300 Longwood Avenue		
City	State	Zip Code
Boston	MA	02115
Business Phone		
617 735-6000		
Name and Location of Health Care Facility (if known)		

Nature of Complaint

- | | |
|--|--|
| <input type="checkbox"/> Substandard Medical Care | <input type="checkbox"/> Drug Dealing |
| <input checked="" type="checkbox"/> Professional Misconduct | <input type="checkbox"/> Criminal Conviction |
| <input type="checkbox"/> Sexual Misconduct | <input type="checkbox"/> Patient Neglect/Abandonment |
| <input type="checkbox"/> Rude or Discourteous Behavior | <input type="checkbox"/> Unlawful Discrimination |
| <input type="checkbox"/> Impaired by Alcohol or Drugs | <input type="checkbox"/> Billing for Services Not Rendered |
| <input type="checkbox"/> Impaired by Mental or Emotional Illness | <input type="checkbox"/> Failure to Supervise Staff |
| <input type="checkbox"/> Failure to Provide Medical Records | <input type="checkbox"/> False Advertising |
| <input type="checkbox"/> Overcharge for Medical Records | <input type="checkbox"/> Fraud |
| <input type="checkbox"/> Other | |

Please do not write below this line.

Failure to complete and sign this release may prevent investigation of your complaint.

Release of Medical Records and Information

Patient Name: _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

Signature of Patient: _____ Date: 3/29/99
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT WITH AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233, § 20B.

Signature of Patient: _____ Date: 3/29/99
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

If you are not the patient, what is your relationship to the patient?

☐ Spouse, ☒ Parent, ☐ Child, ☐ Other Relative _____, ☐ Friend, ☐ Attorney, ☐ Other _____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)

☐ Yes, ☐ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?

☐ Yes, ☐ No

How long have you (or patient) been under this physician's care?

☐ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.

☐ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Tricare

☐ Workers' Compensation, ☐ Self, ☐ Other _____

Are you (or patient) expected to pay a portion of this bill out of pocket?

☐ Yes, ☐ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?

☐ Yes, ☐ No

Is the fee or copayment in dispute?

☐ Yes, ☐ No

Has the physician been contacted about this complaint?

☐ Yes, ☐ No

Dates of Treatment: _____

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

Dr. Newberger was overly and unprofessionally aggressive in reporting alleged abuse that never occurred on my son.

Dr. Newberger did not state in his written report to the court which reports/material he scheduled to review.

He did not contact my son's former therapist designated by the courts & Department of Social Services, hereinafter referred to as "DSS".

He did not contact my therapist designated by the courts or DSS

He did not contact the Protective Service staff at the New Bedford Child and Family Services who managed this case.

Dr. Newberger never contacted any of the list of professionals (including my former _____ that I provided to Dr. Newberger during his interview with me. Dr. Newberger assured me he would contact these people. To my knowledge, Dr. Newberger never reviewed any of the DSS service plans.

Dr. Newberger did not interview me with my son.

Dr. Newberger based his report on a vengeful mother who refused to cooperate with New Bedford Child and Family staff (where she initially brought my son for treatment without my knowledge).

In short, Dr. Newberger was intent on finding abuse where none existed and destroyed my relationship with my son in order to support the abuse allegations for which he is now famous....

Attach copies of related documents to this form.

The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: _____

_____ Date: _____

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111