REDACTED COPY

RECEIVED
FEB 16 2011
Board of Registration in Medicine

Application #: 246878
Date of Issue: ___/___/___

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: [X] U.S./Canadian Graduate [ ] International Graduate

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

Delk — Last Name (type or print clearly)
Carolyn — First
Elizabeth — Middle
Suffix (Jr., etc.)

[ ] M.D. [X] D.O. [ ] Ph.D [ ] Other degree________ [ ] Male [X] Female

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

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

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

Place of Birth: Winchester (City) MA (State/Province/Territory) Country if not USA

*Mailing Address: ________ Number and Street ________ Telephone: ________

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

Home Address: ________ Number and Street ________ Telephone: ________

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

Business Address: 759 Chestnut St (Number and Street) Telephone: (413) 794-0000

Springfield (City) MA (State/Province/Territory) 01199 (Zip (or postal) Code)

E-mail Address: ________ Fax number: (413) 794-8166

Are you applying for licensure through FCVS? (See instructions page 12) [ ] Yes [X] No

* The Board will use your Mailing Address for all correspondence

CK. #316
02/17/11
WL

PRINT NAME: Carolyn Delk

Pre-medical School

Facility: Smith College Degree: BA From / / To / /
Street: 1 College Ave City: Northampton State: MA

Facility: ________ Degree: ____ / / / /
Street: ________ City: ________ State: ____

Medical School

Facility: Touro University College of Osteopathic Medicine Degree: DO From 8/20/03 To 6/3/07
Street: 1310 Johnson Lane City: Vallejo State: CA

Facility: ________ Degree: ____ / / / /
Street: ________ City: ________ State: ____

Date of medical school graduation: 6 / 3 / 07
Month Day Year

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

Postgraduate Education:

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

Facility: Baystate Medical Center Position: Resident From 7/1/07 To 6/30/11 now
Street: 759 Chestnut St City: Springfield State: MA

Facility: ________ Position: ________ / / / /
Street: ________ City: ________ State: ____

Facility: ________ Position: ________ / / / /
Street: ________ City: ________ State: ____

Facility: ________ Position: ________ / / / /
Street: ________ City: ________ State: ____

Facility: ________ Position: ________ / / / /
Street: ________ City: ________ State: ____

PRINT NAME: Carolyn Delk

Pre-medical School

Facility: Smith College Degree: BA From 9/1/99 To 5/15/03
Street: 7 College Lane City: Northampton State: MA

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Medical School

Facility: Touro University College of Osteopathic Medicine Degree: DO From 9/1/03 To 6/1/07
Street: 1310 Johnson Lane City: Vallejo State: CA

Facility: ______ Degree: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Date of medical school graduation: 6 / 1 / 2003
Month Day Year

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

Postgraduate Education:

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

Facility: Baystate Medical Center Position: resident From 7/1/07 To 6/30/11
Street: 759 Chestnut St City: Springfield State: MA

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

Facility: ______ Position: ______ __/__/__ __/__/__
Street: ______ City: ______ State: ______

06/22/12 535
51 5 04/13/11

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P)	Failed (F)	Number of attempts
USMLE Step I		☐ P	☐ F	
USMLE Step II		☐ P	☐ F	
USMLE Step III		☐ P	☐ F	
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1	6/7/2005	☒ P	☐ F	1
COMLEX Level 2	8/23/2006	☒ P	☐ F	1
COMLEX Level 3	2/26/2009	☒ P	☐ F	1
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

PRINT NAME: Carolyn Delk PAGE 4 OF 5

Hospital Affiliations and Employment

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

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

1. List other states (abbreviations) where you are currently or have ever had a full license: None (resident doctor in MA currently)
2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☒ Yes ☐ No
3. List Board Certification(s): ____ Certification date: __/__/__
   ____ Certification date: __/__/__
4. List your practice specialt(ies) OB/GYN
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Starting work as faculty at Baystate
7. Name of Facility: Baystate Medical Center
   Address: 759 Chestnut St City: Springfield
8. Anticipated starting date in Massachusetts: 8/1/2011

Under the penalties of perjury, I declare that I have examined this full 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 a full 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 of Applicant: [signature]

2 / 27 / 11
Month Day Year

(Continued on page5)

PRINT NAME: Carolyn Delk

Hospital Affiliations and Employment

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

		From	To
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______	State: ______	
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______	State: ______	
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______	State: ______	
Facility: ______	Position: ______	__/__/__	__/__/__
Street: ______	City: ______	State: ______	

1. List other states (abbreviations) where you are currently or have ever had a full license: ____ ____ ____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): (Pending exam) Certification date: __/__/__
   ______ Certification date: __/__/__

4. List your practice specialt(ies) OB/GYN

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

6. Reason for requesting a Massachusetts medical license: employment at Baystate Medical Center

7. Name of Facility: Baystate Medical Center
   Address: 759 Chestnut St City: Springfield

8. Anticipated starting date in Massachusetts: 8 / 1 / 2011

Under the penalties of perjury, I declare that I have examined this full 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 a full 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.

C Delk
Signature of Applicant

1 / 30 / 2011
Month Day Year

(Continued on page5)

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 were **required to obtain an NPI by May 23, 2007.**

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: 1574772497

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.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: ____________________ Date: 1 / 30 / 11

SUPPLEMENT FORM

PRINT NAME: Carolyn Delk DATE: 1 / 30 / 11

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

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

Applicant's Signature: CDelk Date: 1 / 30 / 11

YES **NO**

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

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

9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

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

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

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

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

13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?

14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature: Cllln **Date:** 1 / 30 / 11

Full License Application

FEB 2 2 2011

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

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

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: [signature] Date of Birth ______

Print or Type Name: Delk (Last name) Carolyn (First Name) E (Middle Initial) Social Security No: ______

Other Name(s) ______ (Please type or print name(s))

Name of Medical School: Touro University College of Osteopathic Medicine

Address: 1310 Johnson Lane City: Vallejo State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

______

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

If "yes," indicate where the applicant completed premedical school:

Applicant's Undergraduate School: ______

Undergraduate School Address: ______

(Continued on page 2)

03/02/2011 02:25 7076385267 BOARD OF MEDICINE REGISTRAR PAGE 02/02
FEB. 23. 2011 3:19PM NO. 1372 P. 1

Full License Application

Enrollment and Participation: Our records indicate that Dew, Carolyn E.
(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/20/03	6/20/04	6/20/06	6/3/07
	8/13/04	6/19/05	/ /	/ /
	6/20/05	6/19/06	/ /	/ /

# of weeks or # months — Thank you!

The applicant attended 242 total weeks or ______ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

grad date please Thanks!

check one ☑ was awarded a degree in Dr. of Osteopathic Medicine on (month/day/year) 6/3/07

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

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

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

COMMENTS: ______

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized). INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: [signature]
Print Name: Dr. Harold Barrero
Title: Registrar
Date: 2/14/11 Telephone: (707) 658-5984

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Seal Verified
DATE: 2.23.2011
INITIALS: [initials]

RECEIVED

FEB - 9 2011

Board of Registration in Medicine

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MALPRACTICE HISTORY

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

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

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

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

Liability Carrier: Baystate Health Insurance Company, LTD From: 7 / 07 To: 7 / 11
City: Grand Cayman State: Cayman Islands Policy Number: # 10110 (current)

Liability Carrier: ____________ From: __/__ To: __/__
City: ____________ State: ______ Policy Number: ________

Liability Carrier: ____________ From: __/__ To: __/__
City: ____________ State: ______ Policy Number: ________

Applicant's signature: [signature] 1 / 30 / 11
Date

Print Name: Carolyn Delk

Address: ____________ City: ________

State: ____________ Zip code: ________

Additional forms available at the Board's website at www.massmedboard.org

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 1/30/11

Print or Type Name: Carolyn Delk

Name of Institution: Baystate Medical Center

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Baystate Medical Center

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

Enrollment and Participation: Our records indicate that Carolyn Delk (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1	OB/GYN	7/1/07	6/30/08	yes	ACGME
"	2	"	7/1/08	6/30/09	yes	"
"	3	"	7/1/09	6/30/10	yes	"
"	4	"	7/1/10	6/30/11	Anticipated	"

(Continued on page 2)

51 1 1/15/11

APPLICANT'S NAME: ~~Heather~~ Heather Carolyn Delk

POSTGRADUATE VERIFICATION FORM PAGE - 2

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

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

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

COMMENTS: ________

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

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: [signature]

Print Name: HEATHER Z SANKEY

Academic Title: Program Director

Telephone: (413) 794.5321 Today's Date: 2 / 3 / 2011

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Tanya M. Vanan [signature]
Tanya M. Vanan.

My commission expires: 12/15/2011

Seal Verified
DATE: 2-23-2011
INITIALS: tcd

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

Current Status: Active **License Expiration Date:** 2/20/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address: 759 Chestnut St.
Springfield
Massachusetts - 01199
United States of America
(413) 794-0000

3) **Email Address:**

4) **Fax Number:** (413) 794-8166

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

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
Baystate Health - Brightwood Health Center	Springfield, MA
Baystate Medical Center	Springfield, MA

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

Wing Memorial Hospital Ludlow, MA

11) Care of patients in Massachusetts
Average weekly hours involved in: a) **inpatient care** 12 hrs/wk
b) **outpatient care** 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Medical Center Self Insured	08/01/2011	10/01/2012	Occurrence Policy

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

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: Carolyn E Delk, D.O. **License No.:** 246878

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Carolyn Delk, DO

EDUCATION

Baystate Medical Center, Springfield MA
Obstetrics and Gynecology, PGY-3 — 2007-present, graduation anticipated 6/2011

Doctor of Osteopathy, Touro University College of Osteopathic Medicine
Vallejo, CA — 2003-2007

Level 3Community Health Worker; Women's Choice Clinic,
Oakland, CA — 2004-2007

Bachelor of Arts in Neuroscience and Women's Studies, Smith College
Northampton, MA — 1999-2003

AWARDS & HONORS

Notable Teaching Citation, Tufts University	2007-2008
Medical Students for Choice Funded Summer Externship	2004
Medical School Scholarship, Smith College	2003
Howard Hughes Summer Science Research Grant	2000

LICENCING AND EXAMS

Limited License – State of Massachusetts	2007-present
COMLEX Step 1, 2, 2CS, 3 – passed	2005-2009

PROJECTS

Obstetrical Movie Showing, Baystate Medical Center
Presenting film and leading discussion to share obstetrical experiences and knowledge — 2010-present

Delk, Carolyn, and Wiczyk, Halina. "Approach to Health Care for Lesbian and Bisexual Women."
The Female Patient. Vol. 35:1; 2010: 26-29. — 2010

Associate Investigator with Dr. C. Bell and A. Knee, MS; Tufts University School of Medicine,
Baystate Medical Center, Springfield, MA.
Are foley bulb inductions associated with an increased risk of chorioamnionitis; data validation — 2009-present

INTERNATIONAL EXPERIENCE

4 Week Elective – Tropical Medicine, San Jose, Costa Rica — 2007

COMMITEES

Western MA Trans Provider Network	2009-present
Wesson Women's Clinic Flow Committee	2009-present
Graduate Medical Education Consortium Policy Review Committee	2009-2010
Medical Students for Choice, Vice President	2003-2007

LANGUAGE

Competent in medical Spanish, basic skills in conversational Spanish

MEMBERSHIPS

American College of Obstetricians and Gynecologists, Junior Fellow in Training
Massachusetts Medical Society
The Association of Reproductive Health Professionals

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

Current Status: Active **License Expiration Date:** 2/20/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
759 Chestnut St.
Springfield
Massachusetts - 01199
United States of America
(413) 794-0000

3) **Email Address:**

4) **Fax Number:** (413) 794-8166

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
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
Baystate Health - Brightwood Health Center	Springfield, MA
Baystate Medical Center	Springfield, MA

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

Planned Parenthood	Springfield, MA
Wing Memorial Hospital	Ludlow, MA

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Health Insurance Co. Ltd.	10/01/2013	10/01/2014	Claims made with tail coverage

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

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

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

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

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

18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?
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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Carolyn E Delk, D.O. **License No.:** 246878

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