

Application #: 216999  
Date of Issue: \_\_\_\_\_

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

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

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

MARK ALICE GRACE  
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

M.D.  D.O.  Ph.D  Other degree \_\_\_\_\_  Male  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

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

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

Place of Birth: FT. DEFIANCE ARIZONA  
City State/Province/Territory Country if not USA

Home Address: \_\_\_\_\_  
Number and Street  
City State/Province/Territory Zip (or postal) Code

Business Address: 75 FRANCIS ST. DEPT OF OB-GYN  
Number and Street  
BOSTON MA 02115  
City State/Province/Territory Zip (or postal) Code

Business Telephone: (617) 732-6660, ext. 34579 Home Telephone: \_\_\_\_\_

Preferred Mailing Address:  Business Address  Home Address

#1024  
AEO 3/4/03

**Pre-medical School**

Facility: Swarthmore College Degree: BA From 09/01/1990 To 05/30/1994  
Street: 500 College Ave City: Swarthmore State: PA

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ / / / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Medical School**

Facility: Columbia P.S Degree: MD From 09/01/1998 To 05/30/1999  
Street: 630 W. 118th St City: NYC State: NY

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ / / / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Date of medical school graduation: 05/30/1999

**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: Brigham's Women's Hospital Position: PGY 1-4 From 06/20/99 To 06/20/03  
Street: 75 Francis St City: Boston State: MA

Facility: MGH Position: PGY 1-4 From 06/20/99 To 06/20/03  
Street: 55 Fruit St City: Boston State: MA

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ / / / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ / / / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ / / / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

PRINT NAME: Alice G. MARK

**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.

Facility:	Position:	From	To
<u>Brigham &amp; Women's Hospital</u> Street: <u>75 Francis St</u>	<u>Resident</u> City: <u>Boston</u>	<u>6/20/99</u>	<u>6/20/03</u> State: <u>MA</u>
<u>Mass General Hospital</u> Street: <u>55 Fruit St</u>	<u>Resident</u> City: <u>Boston</u>	<u>6/20/99</u>	<u>6/20/03</u> State: <u>MA</u>
Facility: _____ Street: _____	Position: _____ City: _____	_____/_____/____	_____/_____/____ State: _____
Facility: _____ Street: _____	Position: _____ City: _____	_____/_____/____	_____/_____/____ State: _____

- List other states (abbreviations) where you are currently or have ever been licensed: \_\_\_\_\_
- Are you certified by the American Board of Medical Specialties?  Yes  No
- List Board Certification(s): \_\_\_\_\_ Certification date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
\_\_\_\_\_ Certification date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Have you attached an up-to-date copy of your curriculum vitae?  Yes  No
- Reason for requesting a Massachusetts medical license: Employment in Massachusetts after graduation from residency
- Name of Facility: Brigham and Women's Hospital
- Address: 75 Francis St City: Boston
- Anticipated starting date in Massachusetts: 9/1/2003

**Affidavit of Applicant**

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

Alice G. Mark  
Signature of Applicant

3/3/03  
Date

## CURRICULUM VITAE

### Part I: General Information

**Date Prepared:** March 3, 2003

**Name:** Alice G. Mark, M.D.

**Office Address:** Brigham and Women's Hospital  
Department of Ob/Gyn  
75 Francis Street  
Boston, MA 02115

**Home Address:**

**Phone:**

**E-Mail:**

**Place of Birth:** Fort Defiance, Arizona

**Education:**

1990-1994 B.A., Religion, Swarthmore College, Swarthmore PA.

1995-1999 M.D., Columbia University College of Physicians & Surgeons, New York, NY.

**Experience:**

1994-1995 Teacher, English as a Second Language, Ghana International School, Accra, Ghana.

1995 Intern, National Health Service Corps, Plan de Salud del Valle, Frederick, Colorado.

1999 Fellow, Center for the Study of Society and Medicine, Luisa Guidotti Hospital, Mutoko, Zimbabwe.

**Postdoctoral Training:**

1999- present Intern and Resident, Obstetrics & Gynecology, Brigham and Women's Hospital/ Massachusetts General Hospital, Boston MA.

**Licensure:**

1999- present Massachusetts Limited License

**Languages:**

Fluent Spanish, intermediate French.

### **Awards and Honors:**

- 1994 B.A., *magna cum laude*, Swarthmore College
- 1994 Phi Beta Kappa, Swarthmore College
- 1999 Fellowship in Human Rights and Medicine, Columbia University
- 1999 Alpha Omega Alpha, Columbia University
- 2002 Resident Teaching Award, Harvard Medical School

### **Part II: Research, Teaching and Clinical Contributions**

#### **Report of Presentations:**

- Jan 2001 Reducing the risk of multiple gestation in ART. Brigham and Women's Hospital Grand Rounds. Advisor: Mark Hornstein, MD
- Jul 2001 Recurrent pregnancy loss. North Shore Medical Center / Salem Hospital Grand Rounds. Advisor: Joe Hill, M.D.
- Sep 2001 Medical therapy for female sexual dysfunction. Brigham and Women's Hospital Grand Rounds. Advisor: Jan Shifren, M.D.
- Jun 2002 Day 6 estradiol as a predictor of IVF success. Brigham and Women's Hospital Resident Research Day. Advisor: Elizabeth Ginsburg, M.D.
- Jan 2003 Second trimester abortions: a search for solutions. Brigham and Women's Hospital Grand Rounds.

### **Part III: Bibliography**

#### **Original Articles:**

Mark AG, Shifren J. Medical therapy for female sexual dysfunction. Prim Care Update Ob/Gyns 2003; 10(1)40-43.

#### **Abstracts:**

Mark AG, Racowsky C, Jackson KV. Does time of year impact clinical outcomes in IVF? Poster presentation, ASRM, 2002.

Mark AG, Ginsburg ES, Jackson KV, Walsh BW, Racowsky C. Maximizing outcomes for poor responders to controlled ovarian hyperstimulation in IVF: the use of microdose flare GnRH agonist induction to gonadotropin stimulation in women with previous IVF failure. Fertil Steril 2001; 76(3): S231. Poster presentation, ASRM, 2001.

Greenberg J, Economy K, Mark A, Ringer S. In search of "true" birth asphyxia: labor characteristics associated with the asphyxiated term infant. Am J Obstet Gynecol 2001; 185(6):294. Oral presentation (Dr. Economy), SMFM, 2002.

*1999 Good*

Application #: 99-9211-03  
Date Approved:     /    /    

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

**INITIAL LIMITED LICENSE APPLICATION**

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

**CHECK ONE:**

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

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

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

1-A. Name: (Last) SONDHEIMER (First) ALICE (MI) G

1-B. Other Name(s): \_\_\_\_\_

**YES NO**

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

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

2. Current Residence: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

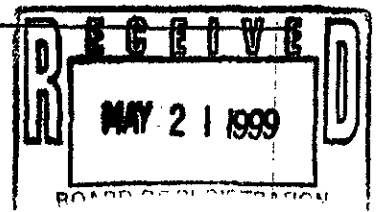
3. Date of Birth: \_\_\_\_\_ Place of Birth: FT. DEFIANCE, AZ USA

4. Sex:  Male  Female      5. Social Security Number: \_\_\_\_\_

6. Name of Massachusetts Training Hospital: BIRGHAM'S WOMEN'S HOSPITAL

75 FRANCIS ST BOSTON  
Street Address City

DATE: 5-21  
INITIAL: LLS  
FEE: \$50.00 Check 301



NAME: ALICE SONDFEIMER

7. Name of premedical school(s): SWARTHMORE COLLEGE  
Location: SWARTHMORE, PA, USA  
(City, State, Country)

8. Name of medical school(s): COLUMBIA UNIV COLLEGE of PHYSICIANS & SURGEONS  
NY 1001  
Location: NY, NY USA  
(City, State, Country)

Year of Graduation: 99 Degree Received:  M. D.  D. O. Other(specify) \_\_\_\_\_

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

Name of Institution: \_\_\_\_\_

Address: \_\_\_\_\_

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

10. List states (abbreviations) where you are currently licensed to practice medicine (include residency training licenses):  
None

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):  
None

12. Medical School Training:

YES NO

a) If you are a USMG, have you taken more than 4 years to complete medical school?

b) If you are an IMG, have you taken more than 6 years to complete medical school?

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

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

SWARTHMORE COLLEGE  
ALICE S. YAM

2000  
2000  
2000

NAME: ALICE SONDHEIMER

Page 3 of 6.

**YES   NO**

14-A. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).

14-B. Have you ever been enrolled in a residency training program(s) that you did not complete, or where you transferred to another program, specialty or facility?

**If you answered "yes" to question 14-A or 14-B, a letter from your program director is required.**

Explanation attached:

Program Director's explanation requested:

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

**YES   NO**

15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?
16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program?
17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).



NAME: ALICE SONDHEIMER

Page 4 of 6

YES NO

21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).
22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you ever voluntarily relinquished medical staff membership?
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
26. Have you ever been charged with any criminal offense, other than a minor traffic offense?
27. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
29. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

NAME: ALICE SONDPHEIMER

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

This certifies that Alice Sondheimer has been appointed  
(Name of Applicant)

to the position of  Intern  Resident  Fellow

in the specialty of Obg OB/GYN as a PGY 921

at BRIGHAM & WOMEN'S HOSPITAL  
(Name of Hospital)

beginning 6/20/99 to anticipated completion of training: 6/30/03  
month day year month day year

**YES NO**

Is the program accredited by the ACGME?

If no, is there an ACGME-approved training program in the applicant's specialty?

Designated Official's Signature: Shawn W Vanner

Type or Print Name: Shawn Vanner, Manager  
Graduate Medical Education

Official Title: \_\_\_\_\_

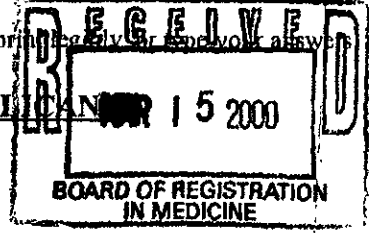
Date: 5/18/99 Telephone Number: 817-732-8540

DATE 4/7/00  
INITIAL: [initials]  
FEE: \$50.00 CHECK

Application #: 9211  
Date Approved: 4/7/00

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

**RENEWAL APPLICATION - LIMITED LICENSE**



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

**SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT**

**SECTION A:**

- Name: (Last) SONDHEIMER (First) ALICE (MI) G
- Mailing Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
- Name of Training Hospital: BRIGHAM'S WOMEN'S
- Current Limited License Number: 99-9211-03
- Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). \_\_\_\_\_  (F)  (L) \_\_\_\_\_  (F)  (L) \_\_\_\_\_  (F)  (L)

**SECTION B: To be completed by program director.**

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

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

Print Name: Robert L. Barbieri, M.D. Date: 3/4/2000  
Signature of Program Director: [Signature] Telephone: 617 732 4260

**To be completed and signed by the designated official of the institution at which the applicant has received an appointment.**

This certifies that Alice Sondheimer has been appointed  
(Name of Applicant)

to the position of:  Intern  Resident  Fellow as a PGY 1

Hospital Name: Brigham & Women's Hosp. Specialty: OB/GYN

Beginning Date: 06/30/99 Anticipated Completion Date of Training: 06/30/2003

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

Designated Official: BETTY SIMPKINS Shawn Vanner, Manager Telephone: 932 4722  
(Print Name) (Title) Graduate Medical Education

Designated Official's Signature: [Signature] Date: 03/07/00

NAME: SONDHEIMER, ALICE G.

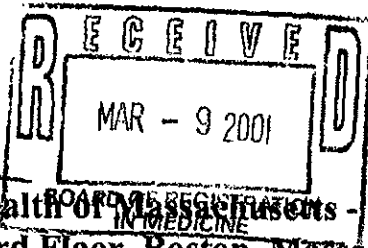
**SECTION C:** Read the instructions. Check either YES or NO to each question. Do not answer N/A.  
If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

YES NO

**SINCE YOUR LAST RENEWAL**

*Note: These questions apply only since your last renewal.*

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate training program?
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?
19. Have you voluntarily surrendered a license to practice medicine or any healing art?
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you voluntarily relinquished medical staff membership?
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
26. Have you been charged with any criminal offense, other than a minor traffic offense?
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to 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?



Application #: 9211  
Date Approved: 3/13/01

DATE: 3/13/01  
INITIAL: CD

Commonwealth of Massachusetts - Board of Registration in Medicine  
10 West Street, Third Floor, Boston, Massachusetts 02111 - www.massmedboard.org

**RENEWAL APPLICATION - LIMITED LICENSE**

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

**SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.**

**SECTION A:**

- 1. Name: (Last) MARK (First) ALICE (MI) G  
Telephone Number: \_\_\_\_\_
- 2. Mailing Address: \_\_\_\_\_  
City: BOSTON State: MA Zip: 02215
- 3. Name of Training Hospital: BWH/MGH
- 4. Current Limited License Number: 99-9211-03
- 5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). \_\_\_\_\_  (F)  (L) \_\_\_\_\_  (F)  (L) \_\_\_\_\_  (F)  (L)

**SECTION B: To be completed by program director.**

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

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

Print Name: Robert L. Barbary, M.D. Date: 2/23/01

Signature of Program Director: [Signature] Telephone: 617-732-4265

**To be completed and signed by the designated official of the institution at which the applicant has received an appointment.**

This certifies that Alice G. Mark, M.D. has been appointed  
(Name of Applicant)

to the position of:  Intern  Resident  Fellow as a PGY \_\_\_\_\_

Hospital Name: Brigham and Women's Hospital Specialty: OB/GYN

Beginning Date: 6/20/99 Anticipated Completion Date of Training: 6/30/03

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

Designated Official: Mary Albertini, Physician Services Telephone: 617-732-9430  
(Print Name) (Title)

Designated Official's Signature: Mary Albertini Date: 3/8/01

NAME: ALICE MARK

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

**THESE QUESTIONS APPLY ONLY SINCE YOUR LAST RENEWAL**

**YES    NO**

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?
17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you, for any reason, been denied a medical license, whether full, limited or temporary or have you withdrawn an application for medical licensure?
19. Have you voluntarily surrendered a license to practice medicine or any healing art?
20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (see definition).
22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you voluntarily relinquished medical staff membership?
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
26. Have you been charged with any criminal offense, other than a minor traffic offense?
27. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
29. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to 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?

## SUPPLEMENT FORM

PRINT NAME:

ALICE G. MARK

DATE:

3 / 3 / 03

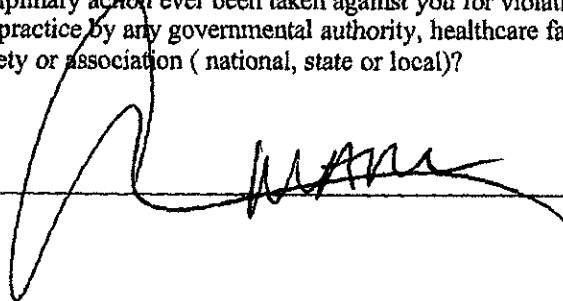
**IMPORTANT NOTE:** If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

### QUESTIONS

YES   NO

1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?
2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?
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 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:



Date:

3 / 3 / 03

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: \_\_\_\_\_

Date: 3,3,03



**MALPRACTICE HISTORY FORM**

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

Liability Carrier: CRICD From: 1/12/03 To: 12/12/03  
City: Cambridge State: MA Policy Number: CAYM-C-GLPL-846-2003

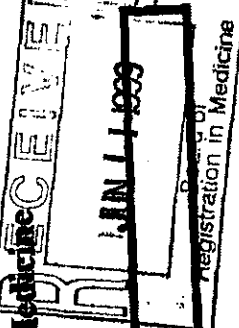
Liability Carrier: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Liability Carrier: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant's signature: [Signature] Date: 03/03/03  
Print Name: Alice G. MARK (policy name - Alice G. Sandheimer)  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip code: \_\_\_\_\_

**You may download additional forms at the Board's website at [www.massmedboard.org](http://www.massmedboard.org).**

UNTER LICENSE APPLICANT



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

MEDICAL EDUCATION VERIFICATION

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

Waiver for Release of Information

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

Applicant's Signature: [Signature] Date of Birth: \_\_\_\_\_  
Print or Type Name: ALICE GRACE SONDHEIMER Social Security No.: \_\_\_\_\_  
Name of Medical School: COLUMBIA U. COLLEGE of PHYSICIANS & SURGEONS State or Province: NY  
Address: 2120 W. 168th St City: NY

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

Yes  No

Premedical Education: Does your school have a premedical school education requirement?

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: SWARTHMORE COLLEGE

Undergraduate School Address: SWARTHMORE, PA

Continued on back

Enrollment and Participation: Our records indicate that

ALICE GRACE SANDHELMER  
(type/print applicant's name: last, first, middle, suffix)

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

ATTENDANCE DATES:	FROM	TO
	<u>8/28/95</u>	<u>6/7/96</u>
	<u>9/3/96</u>	<u>6/11/97</u>
	<u>6/30/97</u>	<u>6/26/98</u>
	<u>7/1/98</u>	<u>5/19/99</u>
	<u>1/1/1/</u>	<u>1/1/1/</u>
	<u>1/1/1/</u>	<u>1/1/1/</u>

The applicant attended 160 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and  
check one  was awarded a degree in MD on (month/day/year) 5/19/99

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.

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

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: Tessy Koikara  
 Print Name: Tessy Koikara  
 Title: Associate Director  
 Date: 6/8/99 Telephone: 212 305-3992

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

05/15/07 10:01

## PART A

1) **Current Status:** Active                      **Renewal Due Date:** 08/05/2007                      **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**

Please make corrections (print)

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

Check here to change this address

**2b) HOME ADDRESS**

Home Address: \_\_\_\_\_  
 City/Town: \_\_\_\_\_ State: \_\_\_\_\_  
 Zip: \_\_\_\_\_ Country: \_\_\_\_\_  
 Home Telephone: (\_\_\_\_) \_\_\_\_\_

*Home address cannot be a Post Office Box*

Phone: \_\_\_\_\_

Check here to change this address

**2c) BUSINESS ADDRESS**

B&W's Hospital - Dept. of OB/GYN  
 75 Francis Street  
 Boston, MA 02115

RECEIVED  
 JUN 22 2007  
 Board of Registration  
 in Medicine

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

*Business address cannot be a Post Office Box*

Phone: (617)732-6660 Ext. 34579

Check here to change this address

3) **E-mail Address:** \_\_\_\_\_

4) **Fax Number:** (617)983-4196

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

\_\_\_\_\_

\_\_\_\_\_

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Obstetrics and Gynecology	<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	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>



# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

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

<b>14) CLAIMS MADE</b> a) <b>NEW:</b> 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) <b>PENDING:</b> Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?	
<b>15) CLAIMS CLOSED</b> 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?	
<b>16) OTHER CIVIL LAWSUITS</b> Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) <b>New:</b> Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) <b>Resolved:</b> Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?	
<b>17) CRIMINAL CHARGES</b> 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?	
<b>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</b> 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?	
<b>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?</b>	
<b>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?</b>	
<b>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?</b>	

<b>22) CME CERTIFICATION:</b> a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> 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. ( <i>See Renewal Instructions, page 8.</i> )  CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training
---

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

## PART C

### Check One:

### PHYSICIAN PROFILE

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

### CERTIFICATIONS

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

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

Signature: \_\_\_\_\_

Date: 6 / 20 / 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.**

05/26/07 01 05



Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite G-4

Boston, MA 02118

617-654-9810

www.massmedboard.org

06/25/07 91 100

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin C. Crane" followed by a flourish.

Martin C. Crane, M.D.  
Board Chair

**Please complete the NPI form on the following page.**



# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

## 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](http://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](http://www.massmedboard.org).
- Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
- Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
- Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- My current NPI is: 

1	9	8	7	6	1	3	1	9	6
---	---	---	---	---	---	---	---	---	---
- I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- I have applied for an NPI using a third party (enter name): \_\_\_\_\_ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

## HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 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:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>2</td><td>0</td><td>7</td><td>V</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>X</td></tr></table>	2	0	7	V	0	0	0	0	0	X	<u>OB/gyn</u>
2	0	7	V	0	0	0	0	0	X			
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											

## 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): AZ 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.

### Authorization for NPI Dissemination

Check one box:  I authorize  I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.

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

Signature: \_\_\_\_\_ Date: 6/12/07

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark

License No.: 216999

## PART A

1) Current Status: Active

Renewal Due Date: 08/05/2005

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.

Please make corrections (print)

2a) MAILING ADDRESS

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

Check here to change this address

2b) HOME ADDRESS

Home Address: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Telephone: (\_\_\_\_) \_\_\_\_\_

Phone:

Check here to change this address

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

B&W's Hospital - Dept. of Ob/Gyn  
75 Francis Street  
Boston, MA 02115

Phone: (617)732-6660 Ext. 34579

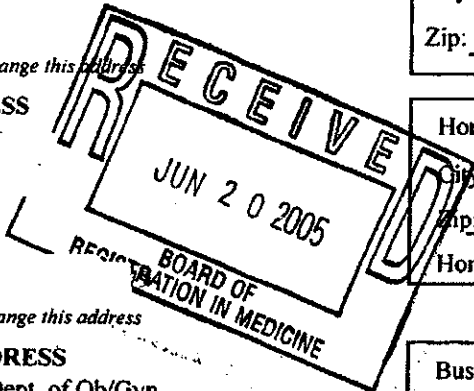
Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: \_\_\_\_\_

4) Fax Number: 617-983-4196



5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Obstetrics and Gynecology	<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?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<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"/>

06/21/05 5:11

9.

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark

License No.: 216999

(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: Hospital

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	
Brigham & Women's Hospital	<input type="checkbox"/>	X		30
Southern Jamaica Plain Health Center	<input type="checkbox"/>	X		30
Women's Health Services 822 Boylston	<input type="checkbox"/>	X		5
	<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 20 hrs/wk Change to: 30 hrs/wk

b) outpatient care 20 hrs/wk Change to: 30 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 1/1/05 To 12/31/05  
(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): \_\_\_\_\_

06/21/05 ST 10

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark

License No.: 216999

06/21/05 ST 11

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

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

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

	YES	NO
<b>14) CLAIMS MADE</b> 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?		
<b>15) CLAIMS PAID</b> 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?		
<b>16) OTHER CIVIL LAWSUITS</b> 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?		
<b>17) CRIMINAL CHARGES</b> 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?		
<b>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?</b>		
<b>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?</b>		
<b>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?</b>		
<b>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?</b>		

<b>22) CME CERTIFICATION:</b> a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. <i>(See Renewal Instructions, page 8.)</i> c) If you are exempt from CME requirements, check reason for exemption. <i>(See Renewal Instructions, page 8.)</i> <b>CME EXEMPTION:</b> (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training
--

# Massachusetts Physician Renewal Application

Physician Name: Alice G Mark

License No.: 216999

## PHYSICIAN PROFILE

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

## CERTIFICATIONS

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

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

Signature: \_\_\_\_\_

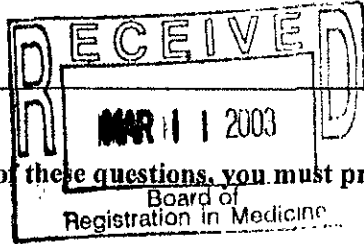
Date: 6/16/05

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

26999

SUPPLEMENT FORM

PRINT NAME: Alice G. Mark



DATE: 3/10/03

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

QUESTIONS

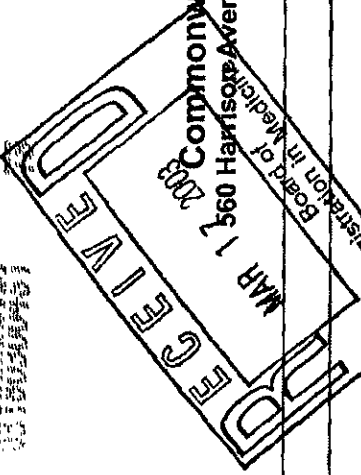
YES : NO

- 1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?
- 2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?
- 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: Alice Grace Sondheimer
- 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 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: \_\_\_\_\_

Date: 3/10/03

030303



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

**Waiver for Release of Information**

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

Applicant's Signature: MARK Date of Birth: \_\_\_\_\_

Print or Type Name: MARK ALICE G. Social Security No: \_\_\_\_\_  
(Last name) (First Name) (Middle Initial)

Other Name(s): SONDHEIMER G.

Name of Medical School: COLUMBIA P.S.

Address: \_\_\_\_\_ City: NY State or Province: NY

**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:

**Promedical 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)

216902

Enrollment and Participation: Our records indicate that Sonderheimer

(type or print the applicant's name): (Last name)

Alice

(First name)

G.

(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
	<u>08 25 1975</u>	<u>06 10 1976</u>	<u>07 10 1978</u>	<u>05 19 1979</u>
	<u>09 03 1976</u>	<u>06 11 1977</u>		
	<u>06 30 1977</u>	<u>06 26 1978</u>		

The applicant attended 160 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one  was awarded a degree in Medicine on (month/day/year) 05/19/97

was NOI 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.

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

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: Carmen E. Sierra

Print Name: CARMEN E. SIERRA

Title: MANAGER

Date: 03 14 2003 Telephone: (812) 305-3992

Seal Verified

DATE: 3/18/03

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

INITIALS: AG



Commonwealth of Massachusetts Board of Registration in Medicine  
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 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: *Alice Grace* Date: 3/10/03  
Print or Type Name: Alice Grace MD  
Name of Institution: Brigham and Women's Hospital

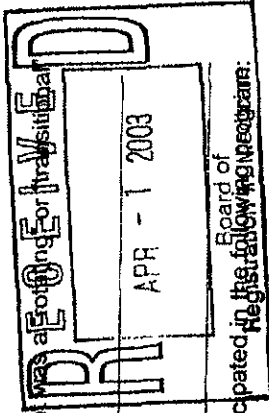
#### INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Brigham & Women's

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

Enrollment and Participation: Our records indicate that Alice Grace MD participated in the following programs:



Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO		
Intern	1		6/20/99	6/30/00	Y	ACGME
Resident	2		7/1/00	6/30/01	Y	
	3		7/1/01	6/30/02	Y	
	4		7/1/02	6/30/03	Y	

506910

APPLICANT'S NAME: Alice Grace Mark

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?  YES  NO
- 2. Was the applicant ever placed on probation?  YES  NO
- 3. Was the applicant ever disciplined or under investigation?  YES  NO
- 4. Were any negative reports ever filed by instructors regarding the applicant?  YES  NO
- 5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?  YES  NO
- 6. During the applicant's participation, our postgraduate medical training  was accredited by:  ACGME  Other.

COMMENTS: An excellent physician

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

**AFFIX INSTITUTIONAL SEAL HERE**

Program Director's Signature: Rosenfeld

Print Name: R. Rosenfeld MD

Academic Title: Chair

Telephone: (415) 732-3444 Today's Date: 3/10/03

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

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



# Physician Registration Renewal Application

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

**RECEIVED**  
OCT 15 2003  
Board of  
Registration in Medicine

- 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.: 216999                      Renewal Date: 09/02/2003

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:

A) Mailing/Business Address:

3. Alice G Mark

B) Home Address:

Home Phone:

Business Phone: (617)732-6660

Please make corrections (print)

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

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

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

Home Address: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_ Country: \_\_\_\_\_  
Home Telephone: (\_\_\_\_) \_\_\_\_\_

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

4. a) Date of Birth: \_\_\_\_\_ b) Sex: F  
c) SS#: \_\_\_\_\_
5. a) Name of Medical School:  
Columbia Univ. College of Physicians & Surgeons  
b) Year Graduated: 1999 c) Degree: M.D.
6. Specialty Code(s) (See Table 1)
- | Code(s) | Hours per Week in Mass. |
|---------|-------------------------|
| 06G     | 40                      |
| 0       | 0                       |

7. Current American Board of Medical Specialties Certification (See Table 2)  
Code: 0G                      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: 921 / ✓ (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: MARK LICENSE NUMBER: 216999

11. My medical malpractice insurance is covered by  Insurance Carrier  Letter of Credit  
 Insurer's name. (Required): CRICO Policy dates: From: 1/1/03 To: 12/31/03  
 Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One:  Not involved in direct/indirect patient care in Massachusetts  A government employee.  
 Otherwise exempt Please explain exemption: no coverage 7/1/03 - 9/1/03. Resumes 9/1/03
12. What is your principal work setting? (See Table 4) 1 0 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.
13. Care of patients in Massachusetts (see instruction booklet).  
 1) Average weekly hours involved in: A) inpatient care 20 hrs/wk B) outpatient care 20 hrs/wk  
 2) What is the approximate percentage of your patient care hours in primary care? 25 %

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

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

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

YES	NO

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date?  Yes  No  
 CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.  
**CME EXEMPTION:** Check one:  Inactive status  Residency/Fellowship training (See instructions).  
 See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.
- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
  - Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
  - Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: [Signature] Date: 7/11/03

**YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION**  
Board Regulations require that you notify the Board, in writing, of any change of address

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

**NATIONAL PROVIDER IDENTIFIER (NPI)**

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

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

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

**Option 1:** Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at [www.NPPES.cms.hhs.gov](http://www.NPPES.cms.hhs.gov).

**Option 2:** Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at [www.massmedboard.org](http://www.massmedboard.org).

**Option 3:** Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

**Option 4:** Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

**Option 5:** If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

My current NPI is:

I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

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

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

As an *inactive* physician, I do not wish to obtain an NPI.

**HIPAA TAXONOMY CODES**

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

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

Provider Taxonomy:

Provider Taxonomy:

Obstetrics & Gynecology

**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): AZ 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.

**Authorization for NPI Dissemination**

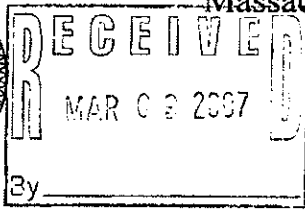
**Check one box:**  I authorize  I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.

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

Signature: \_\_\_\_\_

Date: 3 / 7 / 07

999 210



Massachusetts Board of Registration in Medicine

560 Harrison Avenue, Suite G-4  
Boston, MA 02118  
617-654-9810  
www.massmedboard.org

Dr. Alice G Mark

03/01/2007

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

A handwritten signature in black ink, appearing to read "Martin C. Crane".

Martin C. Crane, M.D.  
Board Chair

**PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU**



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

**Physician Name:** Alice G Mark, M.D.

**License No.:** 216999

**Current Status:** Active

**License Expiration Date:** 9/2/2009

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**  
Boston Medical Center  
850 Harrison Avenue YACC 4S-39  
Boston  
Massachusetts - 02118  
United States of America

**Home Address:**

**Business Address:**  
Boston Medical Center  
850 Harrison Avenue YACC 4S-39  
Boston  
Massachusetts - 02118  
United States of America  
(617) 414-7379

**3) Email Address:**

**4) Fax Number:** (617) 414-3766

**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
Boston University Medical Ctr Hospital	Boston, MA



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

**11) Care of patients in Massachusetts**

Average weekly hours involved in: a) inpatient care 30 hrs/wk  
b) outpatient care 30 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	6/30/2009	6/30/2010	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 Civil Lawsuits**

- 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:** Alice G Mark, M.D.

**License No.:** 216999

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**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, 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:** Alice G Mark, M.D.

**License No.:** 216999

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

**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:** Alice G Mark, M.D.

**License No.:** 216999

**Current Status:** Active

**License Expiration Date:** 9/2/2011

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**

**3) Email Address:**

**4) Fax Number:**

**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**

<b>Massachusetts</b>	<b>Federal (DEA)</b>	<b>Federal (DEA) XS</b>
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**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
	None Reported



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

Physician Name: Alice G Mark, M.D.

License No.: 216999

**11) Care of patients in Massachusetts**

Average weekly hours involved in:

- a) inpatient care 0 hrs/wk  
b) outpatient care 0 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, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility,  
d) Have you been the subject of professional 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:** Alice G Mark, M.D.

**License No.:** 216999

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- 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:** Alice G Mark, M.D.

**License No.:** 216999

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**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: Alice G Mark, M.D.

License No.: 216999

**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:** Alice G Mark, M.D.

**License No.:** 216999

**Current Status:** Active

**License Expiration Date:** 9/2/2013

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**

**3) Email Address:**

**4) Fax Number:**

**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**

<b>Massachusetts</b>	<b>Federal (DEA)</b>	<b>Federal (DEA) XS</b>
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**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
Planned Parenthood League of Mass.	1055 Commonwealth Avenue Boston MA 02215





Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Alice G Mark, M.D.

License No.: 216999

**11) Care of patients in Massachusetts**

Average weekly hours involved in:

- a) inpatient care 0 hrs/wk
- b) outpatient care 5 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
National Union Fire Ins Co of Pittsburgh	01/01/2013	01/01/2014	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?

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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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**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?**



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

**Physician Name:** Alice G Mark, M.D.

**License No.:** 216999

---

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



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

**Physician Name:** Alice G Mark, M.D.

**License No.:** 216999

---

**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:** Alice G Mark, M.D.

**License No.:** 216999

**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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- 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.
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- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
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- 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.