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

Physician Registration Renewal Application

Rec'd PP

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

RECEIVED
SEP 25 2001
BOARD OF REGISTRATION IN MEDICINE

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

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

REDACTED COPY

1. Current Status: Active Registration No.: 41923 Renewal Date: 11/04/2001

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

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

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

3. A) Mailing/Business Address:
AUSTIN J WERTHEIMER
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02446

B) Home Address:

Home Phone:

Business Phone: 617-734-7600

Please make corrections (type or print)

Other Name(s): _____

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

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

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

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

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

c) SS#:

5. a) Name of Medical School: Case Western Reserve University School of Medicine

b) Year Graduated: 1976 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass. 60

GYN 0 Gynecology
0

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

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

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

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

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

Facility Code: 441 / ✓ (AP) 5 % Facility Code: 48 / ✓ (AP) 0 % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 67 / ___ (AP) 1 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: Wertheimer LICENSE NUMBER: 41923

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: ProMutual Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption:
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No
13. A. What is your principal work setting? (See Table 4) 1 5
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 59 hrs/wk b) inpatient care 1 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 20 %

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

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

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

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

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

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

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

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

Signature: Austin Wertheimer Date: 9/22/01

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

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

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

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

RECEIVED
SEP 14 1999
Board of Registration in Medicine

Registration No.: 41923 Renewal Date: 11/04/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
AUSTIN J WERTHEIMER
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02446

B) Home Address:

Home Phone:
Business Phone:

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

5. A) Name of Medical School:
Case Western Reserve University School of Medicine

B) Year Graduated: 1976 C) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
GYN	0	Gynecology
	0	

Please make corrections (type or print)

Other Name(s): _____

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

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

Home: (____) _____
Business: (617) 731-4670

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	60
___ ___ ___	
If OS, Print Specialty:	

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Austin Wertheimer Registration Number: 41923

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

Facility Code: 441/✓ (AP) 80% Facility Code: 48/✓ (AP) 1% Facility Code: ___/___ (AP) ___%

Facility Code: 67/✓ (AP) 19% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

If 999, print name(s): ___

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

Name of Insurer: ProMutual Alternatively, indicate as follows:

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

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

Please explain exemption: ___

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 60 hrs/wk b) inpatient care 000 hrs/wk

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

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

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

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

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

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

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

Signature: Austin Wertheimer Date: 9/12/99

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

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

Registration No.	Status	Fee	Renewal Date
41923	ACTIVE	$150	11/04/91

Dr. AUSTIN J WERTHEIMER

For Office Use Only

MR	_____	__/__/__
Pr	_____	__/__/__
Bk	_____	__/__/__
Ch	_____	__/__/__
D E	_____	__/__/__

Directions:

- *Questions 1-7 include information from Board files Please correct it as necessary*
- *Before proceeding, please read the instruction booklet*
- *Answer all non-optional questions completely (The instructions specify which questions are optional)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes The Board charges $3 00 plus postage for each copy furnished*
- *Enclose the $150 00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts*

ENTERED SEP 3 0 1991

Activity Status:

I am applying to be registered with the following status Active ✓ Inactive _____

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

Pre-Printed Information

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

2 a) Address (Home)

2 b) Address (Business)
1180 BEACON STREET
SUITE 7A
BROOKLINE, MA 02146-

3 Date of Birth Sex M
Lic Issue Date 10/20/77 SSN #
Telephone Number
(Home) - (Business) (617)731-6670

4 Medical School Code OH006 Year Graduated 76 Degree MD
Name of School
Case Western Reserve University School of Meaicine

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

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

Code	Hours per Week in Mass	
GYN	0	Gynecology
	0	

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

Corrections of Pre-Printed Information

Name _____

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

Date of Birth (M/D/Y) __/__/__ Sex (M/F) _____
Lic Issue Date(M/D/Y) __/__/__ SSN # _____

Home (___)_____ Business (___)_____

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

Code	Hours per Week in Mass	
	50	

If OS, write specialty _____

Code _____
Code _____

8 Drug License Number(s) (If any) (optional) a) Federal (DEA)_____ b) How many DEA nos do you have? _____
c) State (MA) #M_____

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

30M 9/90 Pd1397)

[For Office Use Only Waiver Granted_____ Date ____/____/____]

FILL IN NAME AND NUMBER.

Physician Last Name: Wertheimer Registration No 41923

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

List Insurer JUA of MA

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

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

(State how otherwise exempt) _____

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

Facility Code 69 /✓(AP) Facility Code 67 /✓(AP) Facility Code ____ /__(AP)

Facility Code 48 /✓(AP) Facility Code ____ /__(AP) Facility Code ____ /__(AP)

If 999, write Name(s) _____

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

Facility Code ____ Facility Code ____ Facility Code ____ Facility Code ____

If 999, write Name(s) _____

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

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

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

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

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

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 45 hrs /wk in MA

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 5 hrs /wk in MA

14 Principal Work Setting

a) What is your principal work setting? *(See Table 6)* 15

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

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

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

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

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

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

Signature Austin J Wertheimer Date 9, 21, 91

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

Physician Registration Renewal Application

RECEIVED
SEP 15 2003
Board of Registration in Medicine

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

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

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

1. Current Status: Active Registration No. 41923 Renewal Date: 11/04/2003

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. AUSTIN J WERTHEIMER
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02446

B) Home Address:

Home Phone:

Business Phone: 617-734-7600

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: M
c) SS#:

5. a) Name of Medical School:
Case Western Reserve University School of Medicine
b) Year Graduated: 1976 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
GYN	60	Gynecology
	0	

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

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

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

b) States where you 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: 441/2 (AP) ✓ % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: 48/1 (AP) ✓ % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Wertheimer LICENSE NUMBER: 41923

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): ProMutual Policy dates: From: 7/8/03 To: 7/8/04
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.
☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 5 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 0 hrs/wk B) outpatient care 60 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 20 %

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

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

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.
CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).
See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

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

Signature: Austin Wertheimer Date: 9/13/03

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.

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

IMPORTANT — READ, COMPLETE AND SIGN —

PURSUANT TO M.G.L. c 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO OPTIONAL _____

YOU MUST SIGN BELOW

X Austin J Wertheimer
APPLICANT'S SIGNATURE

SEE REVERSE SIDE

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, YOU MUST CHECK THIS BOX: ☑

PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		41923	100.00	100.00	01	15	86	

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

AUSTIN J WERTHEIMER

DO NOT WRITE BELOW THIS LINE

DO NOT FOLD OR STAPLE THIS FORM

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

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
P.O. BOX 6
BOSTON, MASSACHUSETTS 02297

OK

3500600419234 011586 1000000004

Print Name: Austin J. Wertheimer Date of Birth:

Medical School: Case Western Reserve Date of Graduation: 1976 (6/1/76)

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

1. Principal Specialty(ies): obstetrics and gynecology

2. Principal work setting: Hospital

3. Home address: Same as front

4. Principal business address: Boston City Hospital
818 Harrison Ave, Boston 02118

5. List all hospitals at which you have currently effective privileges: University Hospital, Boston City Hospital, Beth Israel Hospital

6. States other than Massachusetts in which you are licensed to practice: none

	YES	NO
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?		
8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?		
9. Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: at least 80 cat. 1, 10 cat. 3, 10 cat. 4

12. I am an active ✓ inactive _____ practitioner. (Check one)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE. Austin J. Wertheimer
SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

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

AS A REGISTERED
PHYSICIAN

IMPORTANT — READ, COMPLETE AND SIGN —

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

SOC SEC NO OR FEDERAL ID NO

YOU MUST SIGN BELOW

X Austin J. Wertheimer
APPLICANT'S SIGNATURE

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

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD		41923	100.00	100.00	01	15	84	

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

AUSTIN J WERTHEIMER

DO NOT WRITE BELOW THIS LINE

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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

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

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

DO NOT FOLD OR STAPLE THIS FORM

3500600419234 011584 10000000009

1. Principal Specialty(ies): * 3 0 | | | 2. Principal work setting: * 3 4

3. Home Address:

4. Primary work address: Beth Israel Hospital
330 Brookline Ave, Boston, MA 02215

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

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

10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows: * 0 3

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE. Austin J. Weissheimer
SIGNATURE

* SEE CODE SHEET

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

Massachusetts Board of Registration in Medicine
Physician Profile

AUSTIN J. WERTHEIMER, MD

This Profile is not available for public release until 18 November 96

I. Physician Information

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

Dr. Wertheimer has been in practice in Massachusetts: 19 years

Accepting new patients? Yes Accepts Medicaid? No

Primary work setting: Private Office

Business address: 1180 Beacon Street
Suite 7-a
Brookline, MA 02146-
Phone: 617-731-6670

Translation services available: None

Insurance Plans Accepted	Hospital Affiliations
HMO Blue	Beth Israel Hospital
JOHN HANCOCK	Deaconess-Waltham Hospital
Cigna	Faulkner Hospital
Harvard Pilgrim Healthcare	Clinic
Tufts	
Other Plans	

II. Education & Training

Medical School: Case Western Reserve University School of Medicine
Graduation Date: 1976

Post Graduate Training: 06/01/76 - 06/30/80 Boston City Hospital

III. Specialty

Gynecology
Board Certified: Board of Obstetrics and Gynecology

IV. Honors and Awards

PHI BETA KAPPA,UNIVERSITY OF ROCHESTER.

V. Professional Publications

INDIRECT COLPOSCOPY AND LASER IN THE MANAGEMENT OF VAGINAL CONDYLOMATA. J REPROD MED. 1986
GONORRHEA:CRITERIA FOR TESTING. AM J MED. 1988
HERPES INFECTION. IBID.
CHLAMYDIA CERVICAL INFECTION: CRITERIA FOR TESTING AM J MED. 1989
CONDYLOMA ACUMINATUM. IN: FRIEDMAN,ED. OBSTETRICAL DECISION MAKING. 1982
HUMAN PAPILLOMAVIRUS INFECTION. ABSTRACT: AMERICAN FEDERATION FOR CLINICAL RESEARCH. 1986

VI. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice

AUSTIN WERTHEIMER, M.D.
1180 Beacon St.
Suite 7-A
Brookline, MA 02146
Telephone (617) 731-6670

To: Wayne Mastin, Board of Registration in Medicine
Fax: 357-8453
Tel: 727-3086, x 343

From: Austin Wertheimer, M.D.
Tel: 731-6670, 683-0462
Fax: 734-0088

Date: October 26, 1996

Re: Revisions for professional publications for Profile

Please call me to confirm receipt of this fax. Thank you.

I counted up spaces, lines, etc. This revision should fit into the space provided on the print-out. Please send me copy of revised profile. Thanks.

Professional Publicatons:

Indirect colposcopy and laser in the management of vaginal condylomata. J Repro Med. 1986

Gonorrhea: criteria for testing. Am J Med. 1988

Chlamydia cervical infection: criteria for testing. Am J Med. 1989

Condyloma acuminatum. In: Friedman, ed. Obstetrical decision making. 1982

Herpes infection. Ibid.

Human papillomavirus infection. Abstract: American Federation for Clinical Research. 1986

10/26/96: Mr. Mastin we're getting there. Please note the correct placement of the "Herpes" reference as noted on accompanying sheet by the arrow and as indicated above. Consistency in punctuation and spacing would make the section read better as well. Thanks

I. PHYSICIAN INFORMATION

AUSTIN (First Name) J (Middle Initial) WERTHEIMER (Last Name) (Suffix)

Make changes to name here

Mass License # 41923
License Status Active

First Issue Date 10/20/77

1180 Beacon St.
Suite 7A
Brookline, MA 02146-3806
U.S.A.
(617) 731-6670

Hospital Affiliation

Beth Israel Hospital
Deaconess-Waltham Hospital
Faulkner Hospital
Clinic

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Itmo Blue — MetraHealth
John Hancock — CIGNA
Harvard Pilgrim
Tufts — Many others

Licenses Held in Other States:

(Please correct as necessary)

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

II. EDUCATION & TRAINING

Case Western Reserve University School of Medicine (Medical School) MD (Degree) 76 (Date)

Make corrections here

Boston City Hospital (Residency Program(s)) 6/76 (Start) 6/80 End

Residency Program(s) Start End

Residency Program(s) Start End

III. SPECIALTY

Primary Specialty: Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology -1982

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

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

.....

.....

VII. MALPRACTICE

Details of claims paid for Dr. WERTHEIMER

No. of Years in Practice: #

Date	Amount Paid 0.0000	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	
Date	Amount Paid	Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, Honors

Phi Beta Kappa, University of Rochester

Publications

Indirect colposcopy and laser vaporization in the management of vaginal condylomata. J Reprod Med. 1986; 31: 39-42.

Am J Med. 1988; 85: 177-182

Am J Med. 1989; 86: 515-520

Note: Please return the survey in the enclosed envelope to:
Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

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

Registration No.	Status	Fee	Renewal Date	Late Fee
41923	ACTIVE	$250.00	11/04/95	$25.00

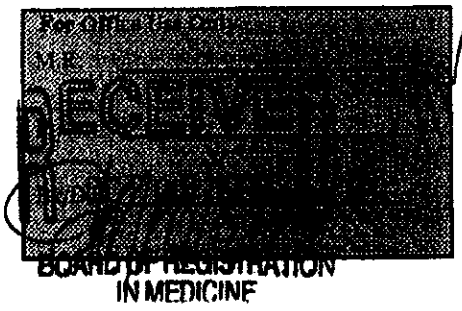
Mailing Address:
AUSTIN J WERTHEIMER, M.D.

Correction of Mailing Address

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

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

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



Pre-Printed Information

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

2. Business Address:
1180 BEACON STREET
SUITE 7A
BROOKLINE, MA 02146

3. Date of Birth: Sex: M
Lic. Issue Date: 10/20/77 SS#:

Home Phone ( ) - Business Phone (617)731-6670

4. Name of Medical School:
Case Western Reserve University
School of Medicine
Year Graduated: 76 Degree: MD

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

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

Code	Hours per Week in Mass.
GYN	50 Gynecology

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

8. Drug license number(s), if any:
a) Federal (DEA)
b) Massachusetts

Corrections of Pre-Printed Information

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

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

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	_____
___ ___ ___	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

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

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

PRINT NAME AND NUMBER: Physician Last Name: Wertheimer Registration Number: 41923

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

Facility Code: 69 / ✓ (AP) Facility Code: 48 / ✓ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 67 / ✓ (AP) Facility Code: 996 / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

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

If 999, write name(s): ___

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

List Insurer: ProMutual

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

State how otherwise exempt: ___

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

13. a) What is your principal work setting? (See Table 4) 15

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

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 48 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 2 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 30 %

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

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

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

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

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

Signature: Austin Wertheimer Date: 9/3995

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

Registration No.	Status	Fee	Renewal Date	Late Fee
41925	ACTIVE	$250.00	11/04/93	$25.00

Mailing Address:
AUSTIN J WERTHEIMER, M.D.

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

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

For Office Use Only
M.R. SEP 30 1993
Pr. FP SEP 30 1993
Bk/D.E. _____

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   1180 BEACON STREET
   SUITE 7A
   BROOKLINE, MA 02146

3. Date of Birth: Sex: M
   Lic. Issue Date: 10/20/77 SS#:
   Telephone Number:
   Home: ( ) - Business: (617)731-6670

4. Name of Medical School:
   Case Western Reserve University School of Medicine
   Year Graduated: 76 Degree: MD

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

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

Code	Hours per Week in Mass.	
GYN	50	Gynecology
O		

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: OG Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:

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

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

Corrections of Pre-Printed Information

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

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

Full Name of Medical School: _____

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

Code	Hours per Week in Mass.

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

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

Staple Check Here

FN

PRINT NAME AND NUMBER: Physician Last Name: Wertheimer Registration Number: 41923

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: MA Medical Professional Insurance Association

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 67 / ✓ (AP) Facility Code: 48 / ✓ (AP) Facility Code: ___ / ___ (AP)
Facility Code: 69 / ✓ (AP) Facility Code: 996 / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 15

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in MA? 45 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 5 hrs/wk in MA

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

IN THE PAST TWO YEARS:	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

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

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

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

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

Signature: Austin J Wertheimer Date: 9/29/93

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

Registration No.	Status	Fee	Renewal Date
41923	ACTIVE	$150	11/04/91

Dr. AUSTIN J WERTHEIMER

For Office Use Only

M.R.	_____	__/__/__
Pr.	_____	__/__/__
Bk.	_____	__/__/__
Ch.	_____	__/__/__
D.E.	_____	__/__/__

ENTERED SEP 30 1991

Directions:

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

Activity Status:

I am applying to be registered with the following status: Active ✓ Inactive_____

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

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

Name:_____

2.a) Address (Home):

Address:_____
City/Town_____
State:_____ Zip:_____
Country Code:_____ (If 999 write Country):_____

2.b) Address (Business):
1180 BEACON STREET
SUITE 7A
BROOKLINE, MA 02146-

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

3. Date of Birth: Sex: M
Lic. Issue Date: 10/20/77 SSN #:

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

Telephone Number:
Home ( ) - Business (617)731-6670

Home: (___)_____ Business: (___)_____

4. Medical School Code: OH006 Year Graduated: 76 Degree: MD
Name of School: Case Western Reserve University School of Medicine

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

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

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

Code	Hours per Week in Mass.	
GYN	0	Gynecology
	0	

Code	Hours per Week in Mass.
	50

If OS, write specialty:_____

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

Code:_____
Code:_____

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

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

[For Office Use Only: Waiver Granted_____ Date:____/____/____]

FILL IN NAME AND NUMBER:

Physician Last Name: Wertheimer Registration No.: 41923

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

List Insurer: JUA of MA

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

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

(State how otherwise exempt): _____

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

Facility Code: 69 /✓(AP) Facility Code: 67 /✓(AP) Facility Code: ___ /__(AP)

Facility Code: 48 /✓(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

If 999, write Name(s): _____

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

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

If 999, write Name(s): _____

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

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

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

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

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

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 45 hrs./wk. in MA.

b) How many hours per typical week are you *currently* involved in *inpatient* care in MA? 5 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? *(See Table 6)* 15

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

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

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

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

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

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

Signature: Austin J. Wertheimer Date 9/21/91

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

Registration No.: 41923 Renewal Date: 11/04/97

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

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

3. A) Mailing/Business Address:
AUSTIN J WERTHEIMER, M.D.
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02146

B) Home Address:

Home Phone: ( ) -
Business Phone: (617)731-6670

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 10/20/77 D) SS#:

5. A) Name of Medical School:
Case Western Reserve University School of Medicine
B) Year Graduated: 76 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
GYN	50	Gynecology

Corrections (type or print)

Other Name(s): _____

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

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

Home: ( ) _____
Business: ( ) _____

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Mass.
___ ___ ___	60
___ ___ ___	

If OS, Print Specialty: _____

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

Code: _____ Code: _____

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

Federal (DEA): ____ _____
Mass: . .

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

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Wertheimer Registration Number: 41923

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

Facility Code: 69 / ✓ (AP) Facility Code: 48 / ✓ (AP) Facility Code: ___ ___ / ___ (AP)
Facility Code: 67 / ✓ (AP) Facility Code: 996 (AP) Facility Code: ___ ___ / ___ (AP)
If 999, print name(s): _____

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

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

If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) X Insurance Carrier ____b) Letter of Credit

Name of Insurer: Pro Mutual

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 60 hrs/wk b) inpatient care _____hrs/wk

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

PART A

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

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption		

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

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

Signature Austin J Wertheimer Date: 9/18/97

BOARD OF REGISTRATION IN MEDICINE

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

SOC. SEC. NUMBER, OPTIONAL ___-___-___

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD	1	41923	$100	100	11	04	87	

AUSTIN J WERTHEIMER

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

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

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

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

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

1. Print Name: Austin J. Wertheimer
2. Date of Birth: ___ (MONTH) ___ (DAY) 49 (YEAR)
3. Medical School: Case Western Reserve M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: U.S.A.
5. Date of Graduation: 6/1/76
6. American Specialty Board Certified? ☑ (Check if yes.)
   Which Boards? American Board of Obstetrics and Gynecology
7. Principal Specialty(ies): Gynecology
8. Principal work setting: Private office
9. Home address: Same as above
10. Principal business address: 1180 Beacon St., Suite 7A, Brookline, MA 02146
11. List all hospitals at which you have currently effective privileges: Beth Israel Hospital, Brookline Hospital
12. List all hospitals at which you have held privileges in the past 20 years: Beth Israel, Brookline, Boston City, University Hospitals
13. States other than Massachusetts in which you are presently licensed to practice: None
14. List any other states where you were previously licensed to practice: None

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

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: Category 1: 63, category 2: 20, 1 hr. 243 CME 3.06-3.14
26. I am an active ☑ inactive ☐ practitioner. (Check One.)

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

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

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

Austin J. Wertheimer M.D.
SIGNATURE

DATE: 9/8/87

(See Reverse Side)

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

016474

Board Use Only:

Registration No.	Status	Fee	Renewal Date
		$150	

RECEIVED SEP 1989

M.R. 9/15/89
Pr. 9/15/89
Bk. ___/___/___
Ch. ___/___/___
D.E. ___/___/___
Fl. E-LAT 10/13/89

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

1. a) Name (LAST:) Wertheimer (FIRST:) Austin (M.I.:) J

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

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

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

2. c) Address (Business): 1180 Beacon St. Suite 7A
Brookline, MA 02146

2. d) Telephone (Business): (617) 731-6670 Extension ____ 2. e) Telephone (Home) *(Optional)*:

3. Date of Birth (MO/DA/YR): 1 4. Sex: MALE ✓ FEMALE ___ 5. Social Security No. *(Optional)*: ___

6. a) Medical School Code *(See Table 1)*: 04006 *If 99999, write* Name: ____

6. b) Year Graduated: 1976 6. c) Degree: M.D. ✓ D.O. ___

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

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

(10 Hospital)	30 %	(15 Private Office)	60 %	20 Partnership/Group Practice	____ %
(25 Clinic)	10 %	30 Mental Health Center	____ %	35 Nursing Home	____ %
40 HMO Facility	____ %	45 Educational Institution	____ %	50 Medical Society	____ %
55 Government Facility	____ %	60 Plant/Commercial Setting	____ %	99 Other	____ %

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

				8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR):
10 Resident or Fellow	____ %	(20 Practice Involving Direct Patient Care)	100 %	10/20/77
30 Administrative Activities	____ %	40 Medical Teaching	____ %	
50 Medical Research	____ %	99 Other	____ %	

9. Specialty Code *(See Table 3)*: GYN Percent of Practice Time: 100% Specialty Code: ___ Percent of Practice Time: ____%
If OS, specify: ____

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

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

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

Facility Code: 069 10 % Facility Code: 048 10 % Facility Code: 067 10 %
Facility Code: ___ ____ % Facility Code: ___ ____ % Facility Code: ___ ____ %

If 999, write Name(s): ____

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

Facility Code: 084 Facility Code: 307 Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s): ____

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

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

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

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

Signature: Austin J Wertheimer (see reverse side) Date: 9/10/89

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

Fill in name and number. **Physician Last Name:** Wertheimer **Registration No.:** 41923

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

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

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

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 145 hrs., Category II: ____hrs., (Risk-Management: 10 hrs.); Residency Program in: ____
Waiver Requested ___ (You must fill out a separate Waiver Form.)

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

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

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

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

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

****

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

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ___ ___ ___		

Massachusetts Physician Renewal Application

Physician Name: AUSTIN J WERTHEIMER **License No.:** 41923

PART A

1) Current Status: Active **Renewal Due Date:** 10/07/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02446

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
1180 BEACON STREET
SUITE 7-A
BROOKLINE, MA 02446

Phone: (617)734-7600

☐ *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: 617-734-0096

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Gynecology	☐	
	☐	
	☐	

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

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	☒	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: AUSTIN J WERTHEIMER **License No.:** 41923

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	___ ___ ___ ___ ___ ___ ___ ___
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	___ ___ ___ ___ ___ ___ ___ ___

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

Principal Work Setting: Private Office Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 50

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

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Beth Israel Deaconess Medical Center	☐	Admitting		1
Faulkner Hospital	☒	Admitting		
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 60 hrs/wk Change to: _____ 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: ProMutual Group Change to: _____

Policy dates: From 7/1/05 To 7/1/06 *(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: AUSTIN J WERTHEIMER **License No.:** 41923

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* ☒ Yes ☐ No

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

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

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

	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: AUSTIN J WERTHEIMER **License No.: 41923**

08/25/05 S1

PHYSICIAN PROFILE

☐ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☒ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

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

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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

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

Signature: Austin Wertheimer Date: 8/17/05

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

Massachusetts Physician Renewal Application

Physician Name: Austin Wertheimer MD **License No.:** 41923

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

☒ My current NPI is: 1 9 7 3 5 9 3 2 5 9

☐ I have personally applied for an NPI.

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:		
Provider Taxonomy:	2 0 7 V G 0 4 0 0 X	Obstetrics-Gynecology - Gynecology
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number: «SS»

State of Birth (if US): Ohio 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.

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

Signature: Austin Wertheimer Date: 1/12/06

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

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

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

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

November 24, 2006

Austin J Wertheimer M.D.
1180 Beacon Street
Suite 7-A
Brookline, MA 02446

Dear Dr. Wertheimer:

Recently you supplied the Board of Registration in Medicine with your National Provider Identifier (NPI) number, or you authorized the Board to apply for this number on your behalf. The Centers for Medicare and Medicaid Services (CMS) requires authorization from the physician in order to disseminate the NPI number to health care providers or authorized agencies.

The Board is the designated repository for electronic storage and dissemination of the NPI number to authorized entities. Providing the NPI information to authorized entities will reduce the amount of administrative duplication in your office. Please sign and date the authorization statement below to allow the Board of Registration in Medicine to disseminate your NPI number to any authorized agency, hospital, health plan, or health organization.

Please return the <u>original signed NPI authorization form</u> in the envelope provided. CMS requires an original signed authorization form for dissemination of your NPI number to health providers or authorized agencies. Thank you.

<u>Authorization for NPI Dissemination</u>

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

Signature: Austin Wertheimer Date: 12/1/06

License Number: 41923

Massachusetts Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

PART A

1) Current Status: Active **Renewal Due Date:** 10/07/2007 **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
1180 Beacon Street
Suite 7-A
Brookline, MA 02446

☐ *Check here to change this address*

RECEIVED
SEP 11 2007
Board of Registration in Medicine

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
1180 Beacon Street
Suite 7-A
Brookline, MA 02446

Phone: (617)734-7600

☐ *Check here to change this address*

3) E-mail Address: _____

4) Fax Number: 617-734-0096

Please make corrections (print)

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

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___)_____

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Gynecology	☐	
	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. License No.: 41923

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

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Beth Israel Deaconess Medical Center			☐
Primary Office	Brookline	MA	☐
Additional office site	Waltham	MA	☐
			☐
			☐

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

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

b) outpatient care 50 hrs/wk Change to: ____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: ____

Policy dates: From 7/8/2007 To 7/8/2008

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: ____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

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

Massachusetts Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.: 41923**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.: 41923**

PART C

Check One: **PHYSICIAN PROFILE**

[X] 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: Austin Wertheimer Date: 9/7/2007

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

Massachusetts Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.: 41923**

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

☒ My current NPI is: 1972593259

☐ 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:	207VG0400X	Obstetrics and gynecology-gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

State of Birth (if US): _____ 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: Austin Wertheimer Date: 9/7/2007

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

Current Status: Active **License Expiration Date:** 11/4/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
1180 Beacon Street
Suite 7-A
Brookline
Massachusetts - 02446
United States of America

Home Address:

Business Address:
1180 Beacon Street
Suite 7-A
Brookline
Massachusetts - 02446
United States of America
(617) 734-7600

3) **Email Address:**

4) **Fax Number:** (617) 734-0096

5) **Specialties**
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
Beth Israel Deaconess Medical Center Primary Office	Brookline

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 50 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	7/8/2009	7/8/2010	Occurrence Policy

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

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

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

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

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

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

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

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

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

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

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

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

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

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: Austin J Wertheimer, M.D. **License No.:** 41923

Current Status: Active **License Expiration Date:** 11/4/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
1180 Beacon Street
Suite 7-A
Brookline
Massachusetts - 02446
United States of America

Home Address:

Business Address:
1180 Beacon Street
Suite 7-A
Brookline
Massachusetts - 02446
United States of America
(617) 734-7600

3) Email Address:

4) Fax Number:

5) Specialties
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
Beth Israel Deaconess Medical Center Primary Office	Brookline

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	07/08/2011	07/08/2012	Occurrence Policy

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

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

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

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

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

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

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

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

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

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

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

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

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

Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

Current Status: Active **License Expiration Date:** 11/4/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
59 Holland Road
Brookline
Massachusetts - 02445
United States of America

Home Address:

Business Address:
59 Holland Road
Brookline
Massachusetts - 02445
United States of America
(617) 733-2886

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
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
Beth Israel Deaconess Medical Center Primary Office	Brookline

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

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

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Coverys	07/08/2013	07/08/2014	Occurrence Policy

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

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

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

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a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
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17) Criminal Charges
a) Have you been charged with any criminal offense during this period?
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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?

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Austin J Wertheimer, M.D. **License No.:** 41923

Compliance with Legal Responsibilities

Online profile:

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

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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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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.

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

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

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

(617) 727-3086

ALEXANDER F FLEMING
EXECUTIVE DIRECTOR

REDACTED COPY

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

March 9, 1993

Austin Wertheimer, M.D.
1180 Beacon Street - Suite 7-A
Brookline, Massachusetts 02146

Re: Complaint No. 93-014

Dear Dr. Wertheimer:

The Complaint Committee of the Board has considered the above referenced complaint, and has determined that no further action is warranted. The complaint has been dismissed. Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please feel free to write to the Director of Enforcement at the above address.

Very truly yours,

Peter Clark
Director of Enforcement

[compdism.let.ovs]

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

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

March 9, 1993

Re:
Complaint No. 93-014

Dear

The Complaint Committee of the Board carefully considered the information you have furnished us regarding the physician named above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues you raised.

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

Should you have any questions or additional material which you wish the Board to consider, please write to the Docket Administrator at the above address. I regret that the Board does not have sufficient staff to respond to telephone inquiries regarding complaints.

Very truly yours,

Peter Clark
Director of Enforcement

compdism.lot(.eva)

Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

January 13, 1993

Austin J. Wertheimer, M.D.

Re: Complaint No. 93-014

Dear Dr. Wertheimer:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Please be advised that Board Regulation 243 CMR 2.07 (12) requires that you respond within thirty days of your receipt of this letter. Your response should be sent to the Docket Administrator, Disciplinary Unit, at the above address. After your response is received, the case will be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Mary F. McGonagle
Docket Administrator

Enclosure

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

(617) 727-3086

ALEXANDER F FLEMING
EXECUTIVE DIRECTOR

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

January 14, 1993

Re: Austin Wertheimer, M.D.
Complaint No. 93-014

Dear

Your complaint regarding the physician named above has been received. The physician involved has been asked to respond in writing to your complaint. Any future correspondence regarding your complaint should include the name of the physician and the complaint number as it appears in this letter.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to the Complaint Department at the address above. Be sure to include the physician's name and the complaint number on all correspondence.

Yours very truly,

Mary F. McGonagle
Docket Administrator

AUSTIN WERTHEIMER, M.D.
1180 Beacon St.
Suite 7-A
Brookline, MA 02146
(617) 731-6670

Janury 27, 1991

Docket Administrator
Disciplinary Unit
Board of Registration in Medicine
Ten West Street
Boston, MA 02111

Dear Sir or Madame:

This is in response to your January 13, 1993 letter requesting that I respond to a complaint filed against me by my pateint has complained that I have acted in an unprofessional manner towards her and have also been neglecting her care. This is why she has chosen to file this complaint with the Board of Registration in Medicine.

has been my patient since March of 1989. She is a year old woman with a history of postural hypotension and Pap smear showing mild dysplasia. She had an appointment on October 23, 1992 for a colposcopy to evaluate the Pap smear abnormality, prior to which my assistant had instructed her not to skip any meals. These instructions are given to minimize the risk of hypovolemia, and therefore to reduce the risk of vasovagal reaction which can sometimes follow an office procedure such as colposcopy. Usually this reaction is mild, occasionally it can be severe.

arrived for her appointment not having eaten anything substantial since the day before. It is my policy not to perform the colposcopy on that day if patients have skipped meals, especially if there is a history of conditions that would predispose to hypotension, as there was in her. I consulted with both and her husband and explained this to them. I also offered additional management options, including an opportunity to reschedule her procedure, but they declined. Even though I thoroughly explained the risks of vasovagal reaction, she and her husband requested that I perform the colposcopy at that time and became increasingly upset as they realized I would not do something against my medical judgment.

I believe that I gave the best possible care and am surprised that she feels I neglected her and did not adequately respond to her questions while she was my patient. I take pride in trying to provide patients with all the information they need so they can better understand the procedures being performed, the risks involved, and the diagnosis of their medical problem.

I would have hoped that would have brought her medical concerns and questions to my attention sooner so that I could have answered all her questions and made her feel more comfortable about her medical care.

Please do not hesitate to contact me should you desire any further information. I appreciate the opportunity to respond to this complaint.

With best regards,

Austin Wertheimer

Austin Wertheimer, M.D.

PLEASE TYPE OR PRINT

YOUR LAST NAME _____ FIRST NAME _____

YOUR STREET ADDRESS _____

YOUR CITY, STATE, ZIP CODE _____

YOUR BUSINESS/DAYTIME PHONE _____ HOME PHONE _____

IS THIS A COMPLAINT AGAINST A ✓ PHYSICIAN (CIRCLE: M.D. OR D.O.) OR _____ ACUPUNCTURIST? (CHECK ONE)

FULL NAME OF PHYSICIAN OR ACUPUNCTURIST (PLEASE CHECK SPELLING FOR ACCURACY)

DR. AUSTIN WERTHEIMER

ADDRESS

1180 BEACON ST

CITY, STATE, ZIP CODE

BROOKLINE MA 02146

BUSINESS PHONE OF PHYSICIAN OR ACUPUNCTURIST

617-731-6670

NAME AND LOCATION OF HEALTH CARE FACILITY (IF KNOWN)

NATURE OF COMPLAINT - PLEASE INDICATE THOSE WHICH BEST DESCRIBE THE NATURE OF YOUR COMPLAINT.

- ___ MEDICAL MALPRACTICE
- ✓ UNPROFESSIONAL CONDUCT
- ___ SEXUAL MISCONDUCT
- ✓ PATIENT ABUSE
- ___ ALCOHOL MISUSE BY PHYSICIAN OR ACUPUNCTURIST
- ___ DRUG MISUSE BY PHYSICIAN OR ACUPUNCTURIST
- ___ MENTAL IMPAIRMENT OF PHYSICIAN OR ACUPUNCTURIST
- ___ DRUG DEALING
- ✓ PATIENT NEGLECT/ABANDONMENT
- ___ CRIMINAL CONVICTION
- ___ PRACTICING WITHOUT A LICENSE
- ___ MEDICAID DISCRIMINATION
- ___ MEDICARE BALANCE BILLING
- ___ FAILURE TO SUPERVISE STAFF
- ___ FAILURE TO SUPERVISE PHYSICIAN ASSISTANT
- ___ FALSE ADVERTISING
- ___ MEDICAL RECORDS, FAILURE TO PROVIDE
- ___ MEDICAL RECORDS, COST
- ___ BILLING DISPUTE
- ___ OTHER _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

BRIEFLY DESCRIBE YOUR COMPLAINT HERE I've been a patient of this Doctor for approximately 4 years, over this time he has talked down to me, told me he couldn't answer my questions - because I would never understand etc. On Oct 23 I arrived to his office for a colposcopy & biopsies scheduled 6 months previously (when the exact procedure was pre-formed on May 8th) I was greeted by his assistant who took my blood pressure and had me drink

ATTACH THE DETAILS OF YOUR COMPLAINT TO THIS FORM. SEND COPIES - NOT ORIGINALS - OF RELATED DOCUMENTS.

YOUR SIGNATURE: (

TODAY'S DATE: 11/2/92

RELEASE OF MEDICAL RECORDS AND INFORMATION

NAME OF PATIENT: _____

ADDRESS: _____

I HEREBY AUTHORIZE THE FOLLOWING PHYSICIAN OR INSTITUTION TO RELEASE MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE BOARD OF REGISTRATION IN MEDICINE, TEN WEST STREET, BOSTON, MASSACHUSETTS 02111

NAME OF PHYSICIAN OR INSTITUTION Austin Wertheimer

ADDRESS: 1180 Beacon St Brookline

DATE OF SERVICES RENDERED Oct 23, 1992

SIGNATURE OF PATIENT _____
(OR LEGAL REPRESENTATIVE)

DATE: 11/20/92

MAIL THIS FORM TO: COMPLAINT COORDINATOR, DISCIPLINARY UNIT
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

FOR OFFICE USE ONLY:

DATE RECEIVED ____/____/____ DOCKET NUMBER _____

orange soda. I had taken tylenol & tea before I left home (prescribed for the pain). At approximately 9 AM Dr. Wertheimer came into the examination room. He began preparing for the procedure when he asked "Are you on some type of ridiculous starvation diet?" I sat up and said no. I hadn't eaten a full breakfast, as I was nervous about the colposcopy & biopsies, yet drank the soda his assistant gave me to increase my blood sugar. Then he abruptly said "I shouldn't even continue with this I don't want to take a risk because you didn't feel like eating breakfast. But since you're here we will do a breast exam, pap smear, and ovary check" I became confused and asked why he would be taking a risk, and what risk he was referring to and if not today when would I have this procedure that concerned me so much? At this point he flippantly said "You probably don't need it anyway, and there's no reason for us to be yelling at one another." My voice may have been shaky yet not loud. I asked if I could consult with my husband who was in the waiting room. Dr. Wertheimer didn't look pleased.

The three of met in his office. The doctor failed to answer the two questions I felt needed answering #1 why did he not care about the advancement of the pre-cancerous cells found 6 months earlier and #2 Did

I need all of the expensive tests, taken over a two year period that caused so much pain and anxiety?

He made it clear I was wasting his time. No reference was made to all the time I spent following up on uncertain health claims.

I feel humiliated by Dr. Wertheimer's nonchalance. He doesn't feel explanations are necessary and did not approach my health and concerns with a serious or professional nature.

I will never step foot into his office again. I hope to find the answers to my questions with your help or on my own.

Sincerely yours