94-0835-98

REDACTED COPY

APR 22 1994

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Initial Limited License Application, Page 1 of 2

$60.00 Fee Payable to The Commonwealth of Massachusetts

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- Answer all non-optional questions (front and back of form) completely--Even though the Board may have the information, it is not adequate to state that the Board already has the information.
- *Sign the application at the bottom of page two.*
- 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.

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ✓ 2) Graduate of Foreign Medical School ___ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___.

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) Goldberg (FIRST:) Alisa (M.I.:) B

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation): NO

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: No

2. a) Name & address of Massachusetts Training Hospital: Brigham + Womens Hosp ; 75 Francis St ; Boston, MA 02115

2. b) Local residence address & telephone : _____ Tel.#( )

3. Place of Birth: Brooklyn, N.Y

4. Date of Birth (MO/DA/YR): ___ ___ ___ 5. Sex: MALE ___ FEMALE ✓ 6. Social Security No. (Optional): ___ ___ ____

7. a). Name of Premedical school(s): Case Western Reserve U. (City, State, Country) 7 b) Location: Cleveland, OH

8. a) Medical School Name: Harvard Medical (See #3 under instructions) 8 b) Location: (City,State,Country) Boston, MA

8. c) Year Graduated: 1994 8. d) Degree: M.D. ✓ D.O. ___ Other: (Specify) _____

9. a) Previous post-graduate training: ___ yes ✓ no MAOOT

b) Name of institution: _____

Address: _____

c) Name of Program: _____ Dates of training: _____

Continue answer on additional page if necessary

10. If you have had any one of the following, please circle which one and attach an explanation to this form: a) Leave of absence from medical school b) USMG more than four years of medical school education. c) FMG more than six years of medical education. Question 10 applies to me ___ Yes ✓ No. I have attached an explanation, Yes ___ No ✓.

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

This certifies that Alisa B. Goldberg has been appointed to the position of Intern ✓ Resident ___ Fellow ___ in Program OB-GYN (Program) at Brigham + Women's Hospital (Institution) beginning 6-20-94

Anticipated completion Date of training 6-30-95 OBG 921

This program is accredited by the ACGME: Yes ✓ No ___

If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

Designated Official's Signature: Shawn Heffernan

Type or Print Name and Title: Shawn Heffernan, GME Program Administrator

(Applicant See reverse side - You must complete Section C)

FORM 11/89

APR 21 1994

Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now fully licensed to practice:
(Abbreviate): N/A

12. States where you previously were licensed to practice (This includes Residency Training Licenses)
(Abbreviate): N/A

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes___ No✓ I have attached an explanation: Yes___ No✓

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No✓ If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes___ No✓ Program Director's Certification has been requested: Yes___ No✓

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	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 a defendant in any criminal proceeding other than a minor traffic offense?:		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) 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? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
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 any 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 been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

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

Applicant's Signature: Alisa Goldberg **Date:** 4, 1, 94

FORM 11/89

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

__Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

M.R.		/ /
Pr.		/ /
Bk.		/ /
Ch.	50-	4/25/95
D.E.		/ /
Fl.		/ /

mportant:

Read the accompanying instructions in their entirety before completing this form.

Print legibly or type your answers.

Answer all non-optional questions (front and back of form) completely--Even though the Board may have the information, it is not adequate to state that the Board already has the information.

Sign the application at the bottom of page two.

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.

ECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

. Name (LAST:) GOLDBERG (FIRST:) ALISA (M.I.:) B

. Mailing Address: _____

. Name & Address of Training Hospital: BRIGHAM + WOMEN'S HOSPITAL 75 FRANCIS ST. BOSTON, MA 02115

. Medical School Name: HARVARD MEDICAL SCHOOL

. Current Limited License Number: 94-0835-98

. To be completed by Program Director:

hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or ending disciplinary action in this program? ___ Yes X No

ype or Print Name and Title Robert L. Barbieri, M.D. - Director, Residency Training Program

ignature of Program Director Robert L Barbieri

ECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN PPOINTMENT.

his certifies that Alisa B. Goldberg has been appointed to the position of Intern ___, Resident ✓,

ellow ___ in Program OB/GYN (Program) at Brigham and Women's Hosp. (Institution) beginning 6-20-95 and nticipated completion date of training 6-30-98

his program is accredited by the ACGME: Yes ✓ No ___

no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

esignated Official's Signature: Shawn Heffernan

SHAWN HEFFERNAN

ype or Print Name and Title: GRADUATE MEDICAL EDUCATION PROGRAM ADMINISTRATOR Date 4-21-95

(Applicant See reverse side - You must complete Section C)

ORM 1/91

RECEIVED
APR 25 1995
BOARD OF REGISTRATION IN MEDICINE

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): NONE

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	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 a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) 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? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
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 any 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 been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature: [signature] Date: 3/19/95

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

5/22 m

__Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee $50	Date

M.R. ____ / / ____

Pr. ____ / / ____

Sk. ____ / / ____

Ch. ____ / / ____

D.E. ____ / / ____

Fl. ____ / / ____

Important:

Read the accompanying instructions in their entirety before completing this form.

Print legibly or type your answers.

Answer all non-optional questions (front and back of form) completely--Even though the Board may have the information, it is not adequate to state that the Board already has the information.

Sign the application at the bottom of page two.

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.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) GOLDBERG (FIRST:) ALISA (M.I.:) B

2. Mailing Address: _____

3. Name & Address of Training Hospital: Brigham & Women's Hosp ; 75 Francis St ASBI-3 ; Boston, MA 02115

4. Medical School Name: Harvard Medical School

5. Current Limited License Number: ~~MD0019AG94~~ 94-0835-98

6. To be completed by Program Director:

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____ Yes __X__ No

Type or Print Name and Title Robert L. Barbieri, M.D. Director Residency Training Program

Signature of Program Director Robert L. Barbieri

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

This certifies that Alisa B. Goldberg has been appointed to the position of Intern ____, Resident __X__,

Fellow ____ in Program OB/GYN (Program) at BRIGHAM & WOMEN'S HOSPITAL (Institution) beginning 6/20/94 and

anticipated completion date of training 6/30/98

This program is accredited by the ACGME: Yes __X__ No ____

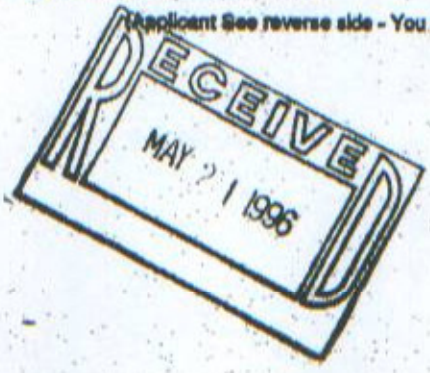
If no, we have an ACGME approved training program in the applicant's specialty: Yes ____ No ____.

Designated Official's Signature: Shawn Vannes

Type or Print Name and Title: Graduate Medical Education Program Administrator Date 5/19/96

FORM 1/91

(Applicant See reverse side - You must complete Section C)



[illegible]TION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

'. Other States where you are now fully licensed to practice:
Abbreviate): N

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
5. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
6. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
7. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
8. 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?		
9. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
10. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
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13. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
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' RESPONSES TO QUESTIONS 16-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD WARE OF THE NEW INFORMATION.

ursuant 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 ix 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 ountry.

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

ill read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in assachusetts.

Hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my nowledge.

pplicant's Signature: [signature] **Date:** 4/9/96

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: $350.00 TO BE SUBMITTED

RECEIVED
MAY 16 1997
BOARD OF REGISTRATION

Filed: 5/16/97 For Office Use Application #
By: VM
Form of Fee: 350 Certificate # 154551 Date of Issue 6/18/97

Please Print

SWORN STATEMENT

Date: 4-20-97

Name Alisa Beth Goldberg (First Middle Last) Address

Date of Birth

Place of Birth Brooklyn, New York

Name on Birth Certificate Same as above Phone #

Pre-Medical Education

School Case Western Reserve Univ.

Years Attended 1986 - 1990

Medical Education

School Harvard Medical School

Years Attended 1990 - 1994

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Brigham + Women's Hospital	OB/Gyn resident	6/94 - 7/98

Is this your first full license? Yes If applicable, please list all other states where you are or have been licensed:

Other names under which you have been licensed:
None

List Specialty Boards by which you are certified:
None

REASON APPLYING FOR A MA LICENSE Moonlighting
Anticipated starting date if you have position pending in Massachusetts: __/__/__

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

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

Date: 4/20/97

SIGNATURE OF APPLICANT

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alisa Beth Goldberg Day time phone #: (617) 732-6660 beep# 5010

MAILING ADDRESS: _____ Business Address: Brigham + Women's Hospital
Dept of OB/Gyn
75 Francis Street
Boston, MA 02115

Address valid until: 7/98

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. 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)? (You must complete Form 1B, attached, for each claim)		X
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		X
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		X
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		X
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		X
6. Have you ever failed a foreign licensing or certification examination?		X
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		X
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?		X
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) 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)?		X
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		X
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		X
12. Have you ever, for any reason, lost American Specialty Board Certification?		X
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____		X
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		X
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		X
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		X
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		X
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		X
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?		X
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		X

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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 will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: _____ DATE: 4/30/97

154551
full

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

RENEWAL APPLICATION - LIMITED LICENSE 94-0835-98

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

SECTION A: Sections A and C on page 2 are to be completed by applicant..

1. Name: (Last) Goldberg (First) ALISA (MI) B
2. Mailing Address: _____ Telephone Number: ( ) -
3. Name and Address of Training Hospital: Brigham + Women's Hospital; 75 Francis St Boston, MA 02115
4. Name of Medical School: Harvard Medical School Year Graduated: 1994
   Location: Boston, MA
5. Current Limited License Number: 94-0835-98
6. Other states (abbreviations) where you are now fully licensed to practice: None

MAY 16 1997
SG SG

TO BE COMPLETED BY PROGRAM DIRECTOR

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

I hereby certify that the above-named physician is in good standing in the Residency or Fellowship indicated above.

Print Name and Title ROBERT Bhargi, M.D., Program Director Date: 1 1

Signature of Program Director ROBERT BARBIERI Telephone (617) 732-4265

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

This certifies that ALISA Goldberg, MD (Name of Applicant) has been appointed to the position of

☐ Intern ☑ Resident ☐ Fellow

Program Name: OB/GYN Location: BRIGHAM & WOMEN'S HOSPITAL

Beginning Date: 6/20/94 Anticipated Completion Date of Training: 6/30/98

Is the program accredited by the ACGME: ☑ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Print Name and Title: Shawn Vanner Graduate Medical Education Program Administrator Telephone 617-732-8540

Designated Official's Signature: Shawn M Vanner Date: 5/12/97

NAME: Alisa Goldberg MD

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

		YES	NO
15.	Since your matriculation in college, have you been subject to any disciplinary action at any academic institution? (See definition).		
16.	Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program?		
17.	Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?		
18.	Have you ever, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?		
19.	Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
20.	Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, international, state or local)?		
21.	Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
22.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
23.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
24.	Have you ever voluntarily relinquished medical staff membership?		
25.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
26.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
27.	Has your privilege to possess, dispense or prescribe controlled substances ever been restricted, revoked, denied or surrendered, or have you ever been called before or warned by this state or any other jurisdiction including a federal agency regarding such privileges?		
28.	In the past ten (10) years, has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
29.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?		

NAME: Alisa Goldberg MD

		YES	NO
30.	Since becoming a medical student, have you been diagnosed with or treated for a medical condition which in any way currently limits or impairs your ability to practice medicine or to function as a physician? (See instructions)		
31.	Do you currently have a medical condition which in any way limits or impairs your ability to practice medicine or to function as a physician? (See instructions)		
32.	In the past year, have you suffered memory loss or impaired judgment for any reason?		
33.	Within the past two (2) years, have you engaged in the use of drugs or alcohol with the result ability to practice medicine is currently limited or impaired?		
34.	Have you ever refused to submit to a test to determine whether you had consumed and/or were under the influence of alcohol or drugs?		
35.	Are you currently engaged in the illegal use of drugs or misuse of prescription drugs?		
36.	Within the past five (5) years, have you voluntarily modified or otherwise limited your of practice for any reason other than a medical condition?		

If your responses to Questions 15-36 change while your application is pending, you must make the Board aware of the new information.

Pursuant to M.G.L. c. 62C, § 49A, I certify under the penalties of perjury that, to the best of my 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 the state or out of the country.)

Pursuant to M.G.L. c. 119, § 51A, I certify that I will fulfill my obligation to report abuse or neglect of children. I will read the Board's regulations, 243 C.M.R. 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I certify under the penalties of perjury that all information on this form (front and back, and all attached pages) is true, to the best of my knowledge.

Applicant's Signature: _____ **Date:** 4/18/97

Revised: 03/03/97

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.**

RECEIVED
APR 21 1998
BOARD OF REGISTRATION IN MEDICINE

Registration No.: 154551 Renewal Date: 05/15/1998

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:

Corrections (type or print):
Other Name(s): _____

3. A) Mailing/Home Address:

ALISA B GOLDBERG, M.D.

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

B) Business Address:
BRIGHAM & WOMEN'S/OB-GYN
75 FRANCIS STREET
BOSTON, MA 02115

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

Home Phone:
Business Phone: (617)732-6660

Home: (____) _____
Business: (____) _____

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 06/18/97 D) SS#:

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

5. A) Name of Medical School:
Harvard Medical School

B) Year Graduated: 1994 C) Degree: MD

Full Name of Medical School: _____

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

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

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology

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

If OS, Print Specialty: _____

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

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

Physician Registration Renewal Application

Before proceeding, *please read the instruction 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.: 154551 Renewal Date: 05/15/2003

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. ALISA B GOLDBERG

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

Mailing Address: 1055 Commonwealth Ave.
City/Town: Boston State: MA
Zip: 02215 Country: USA

Business Address: 1055 Commonwealth Ave
City/Town: Boston State: MA
Zip: 02215 Country:
Business Telephone: (617) 616-1628

Home Address:
City/Town. State:
Zip: ry:
Home Telephone: ( )

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

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

c) SS#:

5. a) Name of Medical School: Harvard Medical School

b) Year Graduated 1994 c) Degree: M.D., MPH

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

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.)
CA

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

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

Facility Code: 921 / ✓ (AP) 20 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 996 / ___ (AP) 80 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s):

PRINT YOUR LAST NAME: Goldberg LICENSE NUMBER: 154551.

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

Insurer's name. (Required): CRICO & Planned Parenthood Policy dates: From: CRICO 2/17/2003 To: current Planned Parenthood 2/1/03 – current

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) 2 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 0-2 hrs/wk B) outpatient care 24 hrs/wk

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

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: _____ Date: 4/3/03

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.

Massachusetts Physician Renewal Application

Physician Name: ALISA B GOLDBERG **License No.:** 154551

PART A

1) Current Status: Active **Renewal Due Date:** 04/17/2005 **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
1055 Commonwealth Avenue
Boston, MA 02215

RECEIVED APR 12 2005 Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

RECEIVED APR 1 2005 BOARD OF REGISTRATION IN MEDICINE

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
1055 Commonwealth Avenue
Boston, MA 02215

Phone: (617)616-1628

☐ *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)616-1675

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

Board Name	**ABMS**	**AOA**
Obstetrics + Gynecology	☒	☐
	☐	☐
	☐	☐
	☐	☐

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

Certificate/Subspecialty	**Correct?**	**Delete?**
Obstetrics & Gynecology	☒	☐
	☐	☐
	☐	☐
	☐	☐

Massachusetts Physician Renewal Application

Physician Name: ALISA B GOLDBERG **License No.:** 154551

(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:	CA
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: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 35

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
Brigham & Women's Hospital	☐	Active		6
Clinic	☐	Active		16
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 2 hrs/wk Change to: 0 hrs/wk

b) outpatient care 24 hrs/wk Change to: 22 hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 2/17/03 To 12/31/05 current

** Also insured through Planned Parenthood 2/1/02 – current (12/31/05) (National Union + Five Insur.)

☐ **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: ALISA B GOLDBERG **License No.:** 154551

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: ALISA B GOLDBERG **License No.: 154551**

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: _____ Date: 3/27/05

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

Massachusetts Physician Renewal Application

Physician Name: Alisa B Goldberg, M.D. **License No.:** 154551

PART A

1) **Current Status:** Active **Renewal Due Date:** 04/17/2007 **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
1055 Commonwealth Avenue
Boston, MA 02215

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Board of Registration in Medicine

☐ *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
1055 Commonwealth Avenue
Boston, MA 02215

Phone: (617)616-1628

☐ *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: 617-616-1675

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

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**List Additional Specialties:**
Obstetrics and 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: Alisa B Goldberg, M.D. **License No.:** 154551

(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:		CA
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		CA

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?
Brigham & Women's Hospital	Boston	MA	☐
Clinic	Boston	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 22 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: CRICO Change to: _____

Policy dates: From 1/1/2007 To 12/31/2007 *MSG incurred through Planned Parenthood & (National Union Fire Insur.) 1/1/02 - 12/31/07

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: **Alisa B Goldberg, M.D.** License No.: **154551**

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: Alisa B Goldberg, M.D. **License No.: 154551**

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 4 / 9 / 07

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