REDACTED COPY

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

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

Registration No.: 38877 Renewal Date: 05/24/2000 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
ARTHUR G SPECTOR

B) Home Address:

Home Phone:
Business Phone:

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

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

B) Year Graduated: 1973 C) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and 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: VT
B) States where you previously were licensed to practice
Abbr: CT

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) 665-1660

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
O B G	60

If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: None
Abbr: VT CT

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

PRINT NAME AND NUMBER: Last Name: Spector Registration Number: 38877

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: 532/__ (AP) 99 % Facility Code: __ __ __/__ (AP) ____% Facility Code: __ __ __/__ (AP) ____%

Facility Code: 42/__ (AP) 1 % 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: Controlled Risk Insurance Co. of Vermont, Inc. Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 20 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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: Arthur G. Spector MD Date: 5 / 8 / 00

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, MA 02111 (617) 727-3086
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. The completed renewal form with attachments must be returned in the *green* envelope *4 weeks* before your renewal date.

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

RECEIVED MAR 20 2002 BOARD OF REGISTRATION IN MEDICINE

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

1. Current Status: Active Registration No.: 38877 Renewal Date: 05/24/2002

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:
ARTHUR G SPECTOR

B) Home Address:

Home Phone:

Business Phone: (781)863-2736

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: (617) 665-2800

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:
Duke University School of Medicine
b) Year Graduated: 1973 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and 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.)
___ ___ VT CT ___ ___ ___ ___

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: 532 / ✓ (AP) 98 % Facility Code: 71 / ✓ (AP) 1 % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 42 / ✓ (AP) 1 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: Spector LICENSE NUMBER: 38877

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Controlled Risk Insurance Co. of Vermont Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 22 hrs/wk b) inpatient care 36 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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: Anthony G Spector MD Date: 3 / 19 / 02

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.

Profile
MMIS 10/1

PHYSICIAN PROFILE

(Information current as of 8/21/96)

Arthur *G.* *Spector*

I. PHYSICIAN INFORMATION

The information in Sections I, II and III has been provided by the physician.

~~114 Waltham St.~~ 57 Bedford St.
Lexington, MA 02173-5409
U.S.A.
(617) 862-1404

Insurance Plan Affiliations

Hospital Affiliations

Mount Auburn Hospital
Martha's Vineyard Hospital
Clinic

Accepting New Patients? *T* yes
Accept-Medicaid? *T* yes

II. EDUCATION AND TRAINING

Medical School: *Duke University School Of Medicine 73*
Post-Graduate Training: Beth Israel Hospital Boston Residency OB/GYN 74-78
Mount Auburn Hospital Cambridge Internship 73-74

III. SPECIALTY

Obstetrics And Gynecology

BOARD CERTIFICATION

Board Of Obstetrics And Gynecology

IV. HONORS AND AWARDS

Up to six entries may be included. Completion of this portion of the profile by the physician is entirely voluntary.

V. PROFESSIONAL PUBLICATIONS

Up to six articles, books or other publications which have been reviewed by a physician's peers prior to publication may be included. Completion of this portion of the profile by the physician is entirely voluntary.

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 history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be subject to litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make the individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occured.
- You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

I. PHYSICIAN INFORMATION

ARTHUR (*First Name*) G (*Middle Initial*) SPECTOR (*Last Name*) (*Suffix*)

Make changes to name here

Mass License # 38877
License Status Active

First Issue Date 07/13/89

114 Waltham St.
Lexington, MA 02173-5409
U.S.A.
(617) 862-1404

Hospital Affiliation

Mount Auburn Hospital
Martha's Vineyard Hospital
Clinic

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

VT

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No

Accept Medicaid? ☒ Yes ☐ No

II. EDUCATION & TRAINING

Duke University School of Medicine (*Medical School*) MD (*Degree*) 73 (*Date*)

Make corrections here

Residency Program(s) *Start* *End*

Residency Program(s) *Start* *End*

Residency Program(s) *Start* *End*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

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
Preterm Health Services	06/01/94	Education/Monitoring

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. SPECTOR

No. of Years in Practice: #

Date	Amount Paid	Basis for Complaint
	0.0000	

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	Publications

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
38877	ACTIVE	$250.00	05/24/96	$25.00

Mailing Address:
ARTHUR G SPECTOR, 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.

For Official Use Only
M.D. _____
Dr _____
DEA _____

Pre-Printed Information

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

2. Business Address:

3. Date of Birth: Sex: M
Lic. Issue Date: 07/13/89 SS#:

Home Phone (617)863-2736 Business Phone (617)862-1404

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

Year Graduated: 73 Degree: MD

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

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

Code	Hours per Week in Mass.	
OBG	44	Obstetrics and 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: 57 Bedford St Suite 130
City/Town: Lexington
State: MA Zip: 02173
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.**

LLS

PRINT NAME AND NUMBER: Physician Last Name: Spector Registration Number: 38877

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: 71 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 42 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

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

If 999, write name(s): ___

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

List Insurer: CRICO

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

State how otherwise exempt: ___

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

13. a) What is your principal work setting? (See Table 4) 20

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? 24 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 24 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 100 %

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~~ pending 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: Arthur G. Spector MD Date: 5/10/96

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
[illegible]	ACTIVE	$250.00	05/24/94	$25.00

Mailing Address:

[illegible] SPECTOR, 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. MAY 12 1994

Pr.

Bk/D.E.

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):

   114 WALTHAM STREET
   LEXINGTON MA 02173

3. Date of Birth: Sex: M
   Lic. Issue Date: 07/10/[illegible] SS#
   Telephone Number:
   Home Business
   (617) 862-1404

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

   Year Graduated: 7[illegible] Degree: MD

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

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

Code	Hours per Week in Mass.
3 4	44 Obstetrics and Gynecology
3	

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: 03 Code:
   b) *If you previously were American Specialty Board certified, but are no longer,* please enter codes of prior certification: (See Table 3)
   Code: Code:

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

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

Corrections of Pre-Printed Information

Name: _____

Address (Home): _____

City/Town: _____

State: _____ Zip: _____

Country Code: _____ If 999 print Country: _____

Address (Business): _____

City/Town: _____

Country Code: _____ If 999 print Country: _____

Date of Birth (M/D/Y): __/__/__ 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

PRINT NAME AND NUMBER: Physician Last Name: SPECTOR Registration Number: 38877

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

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: Controlled Risk Insurance Co. Ltd (CRICO)

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 0 7 1 / ✓ (AP) Facility Code: 0 4 2 / ✓ (AP) Facility Code: 9 9 6 / ___ (AP)
Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 2 0

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? 20 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 24 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? (Made, No Pending, Yes)		
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: Arthur G. Spector MD Date: 5/8/94

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
38377	ACTIVE	$150	05/24/92

Dr. ARTHUR G SPECTOR

For Office Use Only
M.R. ____
Pr. PP 5/21/92
Bk. ____
Ch. ____
D.E. ____

ENTER

Directions:
- *Questions 1-7 include information from Board files. Please co[illegible]s ne[illegible]ary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions s[illegible]hich questions are optional.)*
- *Make a copy of this form and all attachments for your own records [illegible]st 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 [illegible]r 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:

2. a) Address (Home):

2. b) Address (Business):

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

3. Date of Birth: Sex: M
Lic. Issue Date: 07/13/89 SSN #:
Telephone Number:
Home: Business: (617)862-1404

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): ____
Lic. Issue Date(M/D/Y): ___/___/___ SSN #: ____
Home: (____) ____ Business: (____) ____

4. Medical School Code: NC007 Year Graduated: 73 Degree: MD
Name of School:
Duke 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*): VT
b) States where you previously were licensed to practice (*Abbr*): CT

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

Code	Hours per Week in Mass.	
036	40	Obstetrics and Gynecology

Code	Hours per Week in Mass.
____	40
____	____

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:
Code: 03 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? 1
c) State (MA) #M ____

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

30M - 9/90 - PB13971

[For Office Use Only: Waiver Granted ____ Date: ___/___/___]

FILL IN NAME AND NUMBER:

Physician Last Name: SPECTOR

Registration No.: 38877

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

List Insurer: Controlled Risk Insurance Co. Ltd (CRICO)

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

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

(State how otherwise exempt): ____

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

Facility Code: 071 / ✓ (AP) Facility Code: 04[redacted] (AP) Facility Code: ____ / ____ (AP)

Facility Code: ____ / ____ (AP) Facility Code: [redacted] / ____ (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: 998 Facility Code: 001 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? 20 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 24 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? *(See Table 6)* 20

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: Matthew G. Spector MD

Date 5 / 15 / 92

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.: 38877 Renewal Date: 05/24/1998

RECEIVED BOARD OF REGISTRATION IN MEDICINE

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/Home Address:
ARTHUR G SPECTOR, M.D.

B) Business Address:
57 BEDFORD STREET
LEXINGTON, MA 02173-5409

Home Phone:
Business Phone: (781) 862-1404

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 07/13/89 D) SS#:

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

B) Year Graduated: 1973 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	44	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: VT
B) States where you previously were licensed to practice
Abbr: CT

Corrections (type or print)

Other Name(s):

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

Other Address: 1493 Cambridge St
City/Town: Cambridge State: MA
Zip: 02139 Country: USA

Home: ( )
Business: (617) 498-1660

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.
If OS, Print Specialty:

Code: Code:

Federal (DEA):
Mass:

Abbr:
Abbr:

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

PRINT NAME AND NUMBER: Last Name: SPECTOR Registration Number: 38877

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: 1 0 8 / ✓ (AP) Facility Code: 4 2 / ✓ (AP) Facility Code: ___ / ___ (AP)
Facility Code: 7 1 / ✓ (AP) Facility Code: 4 9 6 / ___ (AP) Facility Code: ___ / ___ (AP)
If 999, print name(s): _____

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

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

If 999, write Name(s): _____

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

Name of Insurer: CRICO

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 2 0

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

1) Average weekly hours involved in: a) outpatient care 24 hrs/wk b) inpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 10 %

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 Arthur G. Spector MD Date: 5 / 16 / 98

3 PPF 77

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

[redacted]

CHK 325.00

Board Use Only: Registration No.	Status	Fee $325	Renewal Date
# 38877	OK		

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

RECEIVED 07 07 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 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 $325 fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

1. a) Name (LAST:) Spector (FIRST:) Arthur (M.I.:) G.

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

2. a) Address (Mailing):

2. b) Address (Home): Same

2. c) Address (Business):

2. d) Telephone (Business): (802) 223-6188 Extension ____ 2. e) Telephone (Home) (Optional):

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

6. a) Medical School Code (See Table 1): NC007 If 99999, write Name: NA

6. b) Year Graduated: 1973 6. c) Degree: M.D. X D.O. ___

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

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

10 Hospital	20 %	15 Private Office	80 %	20 Partnership/Group Practice	___ %
25 Clinic	___ %	30 Mental Health Center	___ %	35 Nursing Home	___ %
40 HMO Facility	___ %	45 Educational Institution	___ %	50 Medical Society	___ %
55 Government Facility	___ %	60 Plant/Commercial Setting	___ %	99 Other	___ %

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

10 Resident or Fellow	___ %	20 Practice Involving Direct Patient Care	90 %
30 Administrative Activities	10 %	40 Medical Teaching	___ %
50 Medical Research	___ %	99 Other	___ %

8. b) Mass. Lic. Issue Date (see your wall certificate) (MO/DA/YR): __/__/__

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

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: 998 20 % (100% of hospital time) Facility Code: ____ ___ % Facility Code: ____ ___ %
Facility Code: ____ ___ % Facility Code: ____ ___ % Facility Code: ____ ___ %

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 20 years. (See Table 4.)
Facility Code: 021 Facility Code: 069 Facility Code: 014 Facility Code: 998 x3 Facility Code: ____

If 999, write Name(s):

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

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

Pursuant to M.G.L. c.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 (#) ____ attached pages—is true.

Signature: Arthur G. Spector Date: 6/25/89

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

Fill in name and number. **Physician Last Name:** Spector **Registration No.:** 38817

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

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

13. I am applying to be registered with the following status: ACTIVE X *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 as follows: Past 2 years only *(Fill in # of hours or type of residency, or check waiver.)* Category I: 66.5 hrs., Category II: 67 hrs., (Risk-Management: 6 hrs.); Residency Program in: ______________________; Waiver Requested X (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER X LETTER OF CREDIT ___. *If applicable, check one and identify the name.* Insurer: PHICO 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: 0 % 14. d) *Have you practiced medicine actively and regularly since your license lapsed in Massachusetts? (Y/N)* Y *If No, please attach a letter of explanation.*

Questions 15 through 17: Check either YES or NO (not N/A) to ***each*** *question. Provide details on Form 15A, attached.*

Yes No

15. Has any medical malpractice claim been made against you on or after Jan. 1, 1976 (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 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 on or after Jan. 1, 1976 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 - 24: 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 ever 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, at any time?……………………………

19. Have you ever withdrawn an application for a medical license 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 required recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ……………

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

021828

Board Use Only:

Registration No.	Status	Fee	Renewal Date
38877	1	$150	05/24/90

ARTHUR G SPECTOR

RECEIVED MAY 1990

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

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:) SPECTOR (FIRST:) Arthur (M.I.:) G.

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

2. a) Address (Mailing):

2. b) Address (Home):

2. c) Address (Business): 114 Waltham St
Lexington MA 02173

2. d) Telephone (Business): (617) 862-1404 Extension ____ 2. e) Telephone (Home) *(Optional)*:

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

6. a) Medical School Code *(See Table 1)*: NC007 *If 99999, write Name:*

6. b) Year Graduated: 1973 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	62 %	15 Private Office	25 %	20 Partnership/Group Practice	25 %
25 Clinic	13 %	30 Mental Health Center	____ %	35 Nursing Home	____ %
40 HMO Facility	____ %	45 Educational Institution	____ %	50 Medical Society	____ %
55 Government Facility	____ %	60 Plant/Commercial Setting	____ %	99 Other	____ %

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

10 Resident or Fellow	____ %	20 Practice Involving Direct Patient Care	80 %
30 Administrative Activities	10 %	40 Medical Teaching	10 %
50 Medical Research	____ %	99 Other	____ %

8. b) Mass. Lic. Issue Date *(see your wall certificate)** (MO/DA/YR): 7/1/89
* Never got one, please send one!

9. Specialty Code *(See Table 3)*: OBG 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: 021 62 %	Facility Code: ____ ____ %	Facility Code: ____ ____ %
Facility Code: 001 13 % clinic only	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: 998 Facility Code: 998 Facility Code: 998 Facility Code: 998 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 (#) ____ attached pages--is true.

Signature: Arthur G. Spector (see reverse side) Date: 5 / 22 / 90

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

Fill in name and number. **Physician Last Name:** SPECTOR **Registration No.:** 38827

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

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

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: 104 hrs., Category II: 0 hrs., (Risk-Management: 10 hrs.): Residency Program in: ___;
Waiver Requested___ *(You must fill out a separate Waiver Form.)* Cat III 73 Cat V 37

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer: Controlled Risk Insurance Co. Ltd. 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):* ___ ___ ___		

#14
#15

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
38877	ACTIVE	$250.00	05/24/96	$25.00

Mailing Address:
ARTHUR G SPECTOR, 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

For Office Use Only
M.R. _____
Pr. _____
H/D/R _____

Pre-Printed Information

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

2 Business Address:
~~114 WALTHAM ST~~
LEXINGTON, MA 02173-5409

3 Date of Birth Sex M
Lic. Issue Date 07/13/89 SS#

Home Phone Business Phone
(617)862-1404

4 Name of Medical School
Duke University School of Medicine

Year Graduated 73 Degree: MD

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

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

Code	Hours per Week in Mass	
OBG	44	Obstetrics and 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. 57 Bedford St Suite 130
City/Town Lexington
State. MA Zip 02173
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 Spector Registration Number 38877

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 71 / ✓ (AP) Facility Code ___ / ___ (AP) Facility Code ___ / ___ (AP)

Facility Code 42 / ✓ (AP) Facility Code ___ / ___ (AP) Facility Code ___ / ___ (AP)

If 999, print name(s) ___

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

Facility Code ___ Facility Code ___ Facility Code ___ Facility Code ___ Facility Code ___

If 999, write name(s) ___

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

List Insurer CRICO

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

State how otherwise exempt ___

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

13 a) What is your principal work setting? (See Table 4) 20

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? 24 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 24 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care) 100 %

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~~ pending 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 charge.
- 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 Arthur G. Spector MD Date 5/10/96

#15

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
38877	ACTIVE	$250.00	05/24/94	$25.00

Mailing Address:

[illegible] SHECTOR, [illegible]

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 MAY 12 1994

Pr.

Bk/D.E.

Pre-Printed Information

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

2 a) Address (Home)

b) Address (Business).

[illegible] MALTON STREET
[illegible] MA 02172

POOR QUALITY COPY

3 Date of Birth: Sex
Lic Issue Date 07/12/[illegible] SS#
Telephone Number
Home (617) 965-2731 Business (617) 566-1404

4 Name of Medical School
[illegible] University School of Medicine

Year Graduated: 73 Degree. [illegible]

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

6 Specialty Code(s) (See Table 2)

Code	Hours per Week in Mass
[illegible]	[illegible] Obstetrics and Gynecology

7 a) If you are currently American Specialty Board Certified, enter Codes (See Table 3)
Code [illegible] 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)

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) _____

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

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name SPECTOR Registration Number 38877

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

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

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

List Insurer: Controlled Risk Insurance Co Ltd (CRICO)

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

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

(State how otherwise exempt) ___

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

Facility Code. 0 7 1 / ✓ (AP) Facility Code 0 4 3 / ✓ (AP) Facility Code. 9 9 6 / ___ (AP)

Facility Code ___ / ___ (AP) Facility Code ___ / ___ (AP) Facility Code. ___ / ___ (AP)

If 999, print name(s) ___

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

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

If 999, write name(s) ___

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

14 a) What is your principal work setting? (See Table 5) 2 0

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? 20 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 24 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? (made, No Pending, Yes)		
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: Anthony G. Spector MD Date 5/8/94

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
38877	ACTIVE	$150	05/24/92

Dr. ARTHUR G SPECTOR

RECEIVED MAY 21 BOARD OF REG IN MEDICINE COMMONWEALTH OF MASSACHUSETTS

For Office Use Only

MR ____ / / ____
Pr pf 5/21/92 / / ____
Bk ____ / / ____
Cn ____ / / ____
DE ____ / / ____

Directions.

- *Questions 1-7 include information from Board files Please correct 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.

POOR ORIGINAL COPY

Pre-Printed Information

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

2 a) Address (Home)

2 b) Address (Business)
11 WALTHAM STREET
LEXINGTON, MA 02173-

3 Date of Birth Sex M
Lic Issue Date 07/13/69 SSN #
Telephone Number
Home Business
(617)862-1404

4 Medical School Code NC007 Year Graduated 73 Degree MD
Name of School
Duke University School of Medicine

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

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

Code	Hours per Week in Mass	
03C	50	Obstetrics and Gynecology

7 a) Are you American Specialty Board Certified? (Y/N) Y 7 b) If YES, Enter Codes
Code 03 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
____	40
____	____

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? 1
c) State (MA) #

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 - P813971

[For Office Use Only Waiver Granted ____ Date ___/___/___]