

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. Curre	nt Status: Active	
If you want to chan	ge your current	status, please indicate bele	ow: (Ch	neck one).	$\sqrt{\chi}$	
Active	Retiring (se	e instructions)	Inactiv	ve (see below *)	Do not wish to renew	
2. Other Name(s), i	f any, under wh	ich you were licensed:		Please make corr	rections (type or print)	
				Other Name(s):		
3. A) Mailing/Business Address: ARTHUR G SPECTOR			Mailing Address City/Town:	State:		
B) Home Addre	sa:	W 1 7 200		Other Address:_ City/Town: Zip:	State:	
Home Phone:		A second second	:\ 	Home: ()	
Business Phone:) 666-1660	
 A) Date of Birth B) SS#: 	:	Sex: M		SS#:	M/D/Y):/ Sex : [] M [] F	
5. A) Name of Med	lical School: y School of Me	dicine		Full Name of Med	dical School:	
B) Year Graduate	ed: 1973 C	C) Degree: M.D.		Year Graduated:	Degree: M.D. D.O.	
6. Specialty Code(s) Code(s) OBG 0	(See Table I) per Week in M Obstetrics and	ass. Gynecology		Code(s) OBG	Hours Per Week in Massachusetts	
0			[If OS, Print Specia	alty:	
Current American Code: OG	Board of Medic Code:	cal Specialties Certification	n (See T	able 2)	Code:Code:	
 Drug License Nur A) Federal (DEA B) Massachusetts):				Federal (DEA):	
Abbr: VT		w licensed to practice			Abbr: None Abbr: VT CT	

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

PRINT NAME AND NUMBE	R: Last Name:	Spector	Registrati	ion Number: 3	8877	
the codes from Table 3 and plac each facility, write the approxim	s at which you have e a check mark nex sate percentage of p	completed the credential to those health care fac atient care hours that yo	aling process for the provis ilities where you have adm u provide in each facility	sion of patient uitting privileg	care. Sup ses (AP).	ply Next to
Facility Code: 432/(A	P) 44 % Facili	ty Code:/_ (A	AP)% Facility Code	:/_	_ (AP)	%
Facility Code: _ 4 V/_ (A.	P) / % Facili	ty Code:/(/	AP)% Facility Code	:/	(AP)	%
ii 999, print name(s):						
11. My medical malpractice insu	rance is covered by	(a) 🛛 Insurance Carri	er b) 🔲 Letter of Cr	edit		
Name of Insurer: Controled	Kisk Insurance	Co. of Vermont, Inc	Alternatively, indica	ate as follows:	}	
I am registering with Active statu	is but I am not cove	red by medical malprac	tice insurance because I am	(check one)		
a) Not involved in direct/inc	lirect patient care is	Massachusetts b)	Otherwise exempt			
Please explain exemption:						
12. Are you currently in a post-gr	aduate training pro	gram in Massachusetts a	s a resident or clinical fello	ow? (check on	e) 🔲 Yes	[⊋′No
13. A. What is your principal wo					_	
B. Care of patients in Massac	husetts (see instruc	tion booklet).				
1) Average weekly hours i	nvolved in:	a) outpatient care	hrs/wk b) inpatient ca	re 20 hrs/	wk	
2) What is the approximate						
PART A - QUESTIONS R	EFER ONLY	<u>FO THE PAST TW</u>	O (2) YEARS			
Questions 14 through 22 refer to	the past two (2)	ears only. Check eithe	er YES or NO (NOT N/A)) to each ones	tion. Pro	wide
ucians on furm it for all YES at	iswers except for a	iuestion 22. Refer to th	ia instruction booklet for	additional in	formation	
definitions. You must answer A	LL questions, or ti	us form will be returne	ed to you and your license	renewal may	y be delay	ed.
					YES	NO
 CLAIMS MADE: Has any n settled or adjudicated, whether 	er or not a lawsuit w	as filed in relation to the	claim?	•		
 CLAIMS RESOLVED: He adjudicated, or otherwise reso 	es any medical malp lved, whether or no	oractice claim that has be t a lawsuit was filed in r	en made against you been elation to the claim?	settled,	ì	į
16. Has any lawsuit, other than a r or your professional conduct is otherwise resolved?	nedical malpractice	suit, which is related to	Your competency to practi	ce medicine, dicated or		
Have you been charged with a	ny criminal offense	, other than a minor traff	ic violation?		1	
18. Have you been formally charg practice of any governmental a	ed with or disciplin	ed for any violation of la	we rules by-laws or stone	iards of		
 Has your privilege to possess, revoked, denied or restricted by 	dispense or prescrib	e controlled substances	been surrendered to or sus	pended,		
Have you withdrawn an applic	ation for a medical	license or been denied a	medical license for any re-	ason?		
 Has any professional liability i co-payment, or placed any con you voluntarily restricted, limit professional liability insurance 	nsurance provider r dition related to pro ted or terminated yo	estricted, limited, termin	ated, imposed a surcharge	or or have		
22. CME CERTIFICATION: H	•	your CME requirements	nreceding your renewal de	ate? 📝 Yes		No
CME Waiver requested (C	CME waiver form d	ue 30 days prior to date	of license expiration)		E exempt	
See Instructions for CME require	ments. Do not su	mit documentation of	vour CMEs with your re	newel applied	ns exempt	ion
• Pursuant to G.L. c. 112, § 2, I wi	Il not charge to or co	liect from a Medicare be	neficiary more than the Med	licare foe echo:	tula amaus	
 Pursuant to G.L. c. 62C, § 49A, t Massachusetts state taxes that ar 	o the best of my kno	wiedge and ballof I have	fied all Mannethonests at the			
• Pursuant to G.L. c. 112, § 1A, I	vill fulfill my obliget	ion to report abuse or per	elect of children on new in a	bu CI	Onited Stat	ies.
I hereby certify under the pena	ilties of pertury tha	t all the information on	the Renewal Annibests	oy 6.1., c. 119,	9 51A.	
Signature: John Signature:	S.W.	o	те кенени эррпсинов	Date: 5		00



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

green envelope 4 weeks before your renewal date,	convicted renewal form with attachments must be returned in the
· 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 informations as required.	The distributed and completeness. Make any corrections or
1. Current Status: Active Registration	No.: 38877 Renewal Date: 05/24/2002
If you want to change your current status, please check on	g of the following boxes to indicate your <u>new</u> 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:	Please make corrections (type or print)
•	Other Name(s):
 A) Mailing/Business Address: ARTHUR G SPECTOR 	Mailing Address: City/Town: State:
ARTHUR G STECTOR	City/Town; State:
	Zip: Country:
70 Ft	Business Address:
B) Home Address:	City/Town: State:
	Zip: Country: Business Telephone: (617) 665-2800
,	Home Address:
Home Phone:	City/Town: State:State:State:
(791)862 2726	Home Telephone: ()
Business Phone: (781)863-2736	PLEASE NOTE: No P.O. Box addresses for home or business addresses.
4. a) Date of Birth: b) Sex:	7. Current American Board of Medical Specialties Certification (See Table 2)
c) SS#:	Gode: Code:
	8. Drug License Numbers, if any:
5. a) Name of Medical School:	a) Federal (DEA):
b) Year Graduated: 1973 c) Degree: M.D.	b) Massachusetts: 9. a) Other states where you are now licensed to practice (Abbr.)
Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass.	b) States where you were previously licensed (Abbr.)
OBG 0 Obstetrics and Gynecology	VTCT
 Current health care facilities at which you have completed the codes from <u>Table 3</u> and place a check mark next to the Next to each facility, write the approximate percentage of 	i the credentialing process for the provision of patient care. (Supply ose health care facilities where you have admitting privileges (AP). patient care hours that you provide in each facility).
Facility Code: 532/V(AP) 98 % Facility Code: Facility Code: 42/V(AP) 1 % Facility Code: If 999, print name(s):	71 / V(AP) / % Facility Code: / (AP) % (AP) % Facility Code: / (AP) %

PRINT YOUR LAST NAME: Spectov	LICENSE NUMBER:	38877
11. My medical malpractice insurance is covered by a) I Insurance Carrier Name of Insurer: (ontrolled Risk Insurance Co. of Vermont	b) Letter of Credit Alternatively, indicate as fo	ollows:
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)	-	,
Please explain exemption:		
12. Are you currently in a post-graduate training program in Massachusetts as a	resident or clinical fellow? (ch	eck one) [] Yes []]
13. A. What is your principal work setting? (See Table 4)		
B. Care of patients in Massachusetts (see instruction booklet).		
1) Average weekly hours involved in: a) outpatient care 22	hrs/wk b) inpatient care 3	6 hrs/wk
2) What is the approximate percentage of your patient care hours in prima		
PART A - QUESTIONS REFER ONLY TO THE PAST TWO	(2) YEARS	
Ouestions 14 through 22 refer to the past two (2) years only. Check either \ details on Form R for all YES answers except for question 22. Refer to the indefinitions. You must answer ALL questions, or this form will be returned to	(ES or NO (NOT N/A) to each	nal information and
		YES NO
 CLAIMS MADE: Has any medical malpractice claim been made against you settled or adjudicated, whether or not a lawsuit was filed in relation to the claim. 	ou that has not yet been finally aim?	
 CLAIMS RESOLVED: Has any medical malpractice claim that has been adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relat 	tion to the claim?	1
16. Has any lawsuit, other than a medical malpractice suit, which is related to you or your professional conduct in the practice of medicine, been filed against youtherwise resolved?	ur competency to practice med ou or been settled, adjudicated	icine, or
17. Have you been charged with any criminal offense, other than a minor traffic	violation?	1
 Have you been charged with or disciplined for any violation of laws, rules, by any governmental authority, health care facility, group practice or professions 	y-laws or standards of practice al society or association?	of
19. Has your privilege to possess, dispense or prescribe controlled substances bee restricted by, or surrendered to any state or federal agency?	en suspended, revoked, denied,	
20. Have you withdrawn an application for a medical license or been denied a me	edical license for any reason?	1
21. Has any professional liability insurance provider restricted, limited, terminate co-payment, or placed any condition related to professional competency or co you voluntarily restricted, limited or terminated your insurance coverage in re professional liability insurance provider?	induct on your coverage or have	e
22. CME CERTIFICATION: Have you completed your CME requirements pro	eceding your renewal date?	Yes 🗀 No
CME Waiver requested (CME waiver form due 30 days prior to date of 1		CME exemption
See Instructions for CME requirements. Do not submit documentation of you		pplication.
Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary	more than the Medicare fee sch	edule amount.
Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you	Massachusetts state tay returns	end noid all
 Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am withholding and remitting Child Support. 		_
 Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of 	of children as required by G.L. c.	119, § 51.4.
I hereby certify under the penalties of perjury that all the information on the Signature: Signature: MWG Surveys		
Signature: MMM & July m	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.

PHYSICIAN PROFILE

(Information current as of 8/21/96)

Parkle 10/10

Arthur

G.

Spector

I. PHYSICIAN INFORMATION

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

111 Wahilam St.

Lexington, MA 02173-3409

U.S.A.

(617) 862-1404

Insurance Plan

Hospital Affiliations

Mount Auburn Hospital Martha's Vineyard Hospital Clinic

Accepting New Patients?

Accept-Medicaid?

T Yes

II. EDUCATION AND TRAINING

Medical School:

Duke University School Of Medicine 73

Post-Graduate Training:

Mount Auburn Hospital Cambridge Internship 73-74

III. SPECIALTY

BOARD CERTIFICATION

Obstetrics And Gynecology

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.

ı.	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
	Hospital Affilia	ation	
114 Waltham St. Lexington, MA 02173-5409 U.S.A. (617) 862-1404	Mount Auburn Martha's Viney Clinic		
Make address corrections here:	Make any corrections	to above here:	
Insurance Plan Affiliation:	Licenses Held in Othe		
	YT	Accepting New Patients	s? ⊠Yes □ No
		Accept Medicaid?	XYes ☐ No
The state of the s	(Please correct as ne	cessary)	
. EDUCATION & TRAINING			
Duke University School of Medicine	MD	73	
Medical School	Degree	Date	
take corrections here	NEW TO SEE STATE OF THE SECOND STATE OF THE SECOND		
lesidency Program(s)	Start		End
esidency Program(s)	Start		End
esidency Program(s)	Start		End
• SPECIALTY imary Specialty: Obstetrics and Gyn		CERTIFICATION Board Names Board of Obstatrics	and Compositions
condary Specialty:		g Board Name: Board of Obstetrics g Board Name:	али Gynecology
ake any corrections here:			
une any corrections here:	Make any	v corrections here:	
	Harmon yegobol		
			**** ** ******************************
		The state of the s	

Board of Registration in Medicine

Physician Profile

HOSPITAL	. DISCIPLINE		
	Hospital	Date	Disciplinary Action
Pre	eterm Health Services	06/01/94	Education/Monitoring
he Board of neluded when	i the court system is fully compute	curate data for this category at the present crized. Please list any criminal convictions	 Include conviction date and nature
MALPRAC	TIOP		
	ms paid for Dr. SPECTOR	No. of	Years in Practice: #
Date	Amount Paid 0,000	D Basis for Complaint	
N	Amount Paid Amount Paid	Basis for Complaint	
Date	- market a city	Basis for Complaint	
Date	Amount Paid	Ponis for Commission	
Date	Amount Paid		
PHYSICIAL	N HONORS & PEFR-REVIE		
Please enter a	ny peer-reviewed publications to we ecognition you have been given.	which you have contributed and any awards	for community service or
	Awards, Honors		Publications

********************		William Control of the Control of th	
	*185.175.185.2816		

Board of Registration in Medicine

Physician Profile

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.	Address (Mailing): City/Town: State: Country:
Directions: Before proceeding, please read the instruction booklet. Some of	puestions are optional.
 Faiture to renew in a timely manner will cause your license to lapse as ability to practice medicine in the Commonwealth. (See enclosed letter 	nd may affect your
· Add late fee if necessary.	
 Make a copy of this form and all attachments for your own records - y credentialing and other purposes. The Board will charge a fee for each copy 	you will need copies for y it provides.
See instructions on detachable coupon at bottom of this page.	
Pre-Printed Information	Corrections of Pre-Printed Information
 Other name(s), if any, under which you were licensed: 	the state of the s
2. Business Address:	Name: Address: S7 Bedford ST Suite 130 City/Town: Lexington State: MA Zip: 02173 Country:
3. Date of Birth: Sex: M Lic, Issue Date: 07/13/89 SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Lic. Issue Date (M/D/Y):/ SS#:
Home Phone Business Phone (617) 863-2736 (617) 862-1404 4. Name of Medical School:	Home: () Business: () Full Name of Medical School:
Duke University School of Medicine Year Graduated: 73 Degree: MD	Year Graduated: Degree (MD/DO):
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.	Code Hours per Week in Mass.
OBG 44 Obstetrics and Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (Se	e Table 2) Code: Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts	Federal (DEA): Mass:
 Activity Status: I am applying to be registered with the following status: I hereby certify that if requesting Inactive status, I will not practice n 	

P	RINT NAME AND NUMBER: Physician Last Name: Spector Registration Number:	38877
10 co	D. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. So does from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code:/ (AP) Facility Code:/ (AP) Facility Code:/	upply the
	Facility Code:/ (AP) Facility Code:/ (AP) Facility Code:/	(AP)
1	f 999, print name(s):	
F	b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated (See Table 3) acility Code: Facility	
lf	999, write name(s):	
11	My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, co	neck one.
S	rnatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance be heck One): (i) Not involved in direct/indirect patient care in Massachusetts: (ii) Otherwise exempt:	
12	. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes No (C	heck one)
13	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? ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)	
_	Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide d Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.	stails on
14.	IN THE PAST TWO YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	YES NO
	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?	
	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?	
	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.	rrave you withdrawn an application for a medical license or been denied a medical license for any reason?	
	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.	riave you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?	
24.	Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?	
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 verenewed. 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 reason	able charges.
even	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 knowled all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: The four reside out-of-state or out of the United States.	i ls appiles
	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 a G.L. c. 119, sec. 51A.	
	hereby certify under the pains and panalties of perjury that all information on this form and Forms R-1 and R-2 is true	
Sig	nature:	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 Correction of Mailing Address:
Mailing Address:	Address (Mailing):
CTHUN W SPECTOR, MAD.	
	City/Town:
	State:Country Code (See Table 1):
	Country Code (See Fable 1):
rections: Staple check to bottom of form. Add late fee if Questions 1-8 include information from Board files. Please of provided on the right hand side of the page. Before proceeding, please read the instruction booklet. Some Make a copy of this form and all attachments for your own for credentialing and other purposes. The Board will charge a	equestions are optional. In records - you will need copies a fee for each copy it provides
Enclose the \$250.00 renewal fee by means of a certified check payable to the Commonwealth of Massachusetts.	k, money order or personal check made Bk/D.
e-Printed Information	Corrections of Pre-Printed Information
Other name(s), if any, under which you were licensed:	Corrections of Fre-Frinted Information
, , , , , , , , , , , , , , , , , , ,	Name:
a) Address (Home):	Address (Home):
•	City/Town:
	State: Zin:
	If 999 print Country:
b) Address (Business):	Address (Business): City/Town:
14 WALTHAM STREET	Country Code: If 999 print Country:
CELLETO'LA MA DE175	11 999 print country.
Date of Birth: Sex: 4	Date of Birth (M/D/Y): Sex (M/F): Lic. Issue Date (M/D/Y):/ SS#:
Felephone Number:	Telephone Number
dome Business	Home: () Business: ()
(017) 552-1404	
Name of Medical School:	Full Name of Medical School:
uke university Cohout of Regista	1¢
Year Graduated?	Year Graduated: Degree (MD/DO):
) Other states where you are now licensed to practice (Abbr):) States where you previously were licensed to practice (Abbr)): C7
	Code Hours per Week in Mass.
pecialty Code(s) (See Table 2):	
Code Hours per Week in Mass.	TEOR min was a
2 t. 44 Obstatrics and Synecol 3	
If you are currently American Specialty Board Certified, ente Code: 6.6 Code:	Code:
If you previously were American Specialty Board certified, be please enter codes of prior certification: (See Table 3)	out are no longer,
Code: Code:	Code: Code:
rug License Number(s), if any: a) Federal (DEA)	
b) State (MA)	Federal (DEA): State (MA):
ou must fill out a separate Waiver Form. The waiver must be	eranted by the Board before your linears will be
have completed my CME requirements in the two years preced	ding my renewal date: Yes No, waiver requested

DRINT MANU AND MUNDED	-,
PRINT NAME AND NUMBER: Physician Last Name: SPECTOR Registration Number: 3887	_
 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 List Insurer: Lontrolled Risk Insurance to Ltd. (c) 100)	k o
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: AP) Facility Code: (AP) Facility Code: (AP) Facility Code: (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:	
Made, No Pending Ves YES 15. Has any medical malpractice claim beer made against you, whether or not a lawsuit was filed in relation to the claim?	NO.
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 charge 	5.
 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 y 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: Date: 518194	

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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 38377 ACTIVE	Fee Renewal Date \$150 05/24/92	For Office Use Only		
	R G SPECTOR	M.R.		
VI VI MINING		Pr. Bk.		
		ch.		
		D.E.		
rections:	C			
Questions 1-7 include information	n from Board files. Please co	as no any. ENTELL		
Before proceeding, please read to	he instruction booklet.			
Make a copy of this form and all :	s completely. (The instructions s attachments for your own records	phian questions are petional.)		
\$3.00 plus postage for each copy	furnished.	The Board Char		
Enclose the \$150.00 renewal fee	by means of a certified check, mone	ney or personal check made payable to the Commonwealth of Massachusetts.		
MAILY GRANGE		January System of the Continuous and		
m applying to be registered with the	he following status: Active	Inactive		
I mereby certify that it fe	questing inactive status, i will not	t practice medicine in Massachusette.		
-Printed information		Corrections of Pre-Printed information		
		Constitute of Figure Information		
Other Name(s), if any, under wh	ich you were licensed:	Name:		
a) Addrese (Home):		Address'		
-		Address: City/Town		
		City/TownZip:Zip:		
		Country Code: (If 999 write Country):		
) Address (Business):		Address:		
		City/Town:		
		State: Zip:		
		Country Code: (if 999, write Country):		
Date of Birth:	Sex: M			
Lic. Issue Date: 07/13/89		Date of Birth (M/D/Y):/ Sex (M/F):		
Telephone Number:	OOI(#.	Lic. Issue Date(M/D/Y): / / SSN #:		
Home	Business	Home: () Business: ()		
	(617)862-1404	DUSINGSS: ()		
Medical School Code:N € Q Q 7	Year Graduated: 7 3 Degree:	M D School Code: Year Graduated: Degree (MD/DO):		
Name of School:		If 99999, write School:		
Duke University	School of Medicine	2		
Other States where you are now	licensed to practice (Abbn: V T			
States where you previously were	licensed to practice (Abbr):: T			
Specialty Code(s) (See Table 3).				
Code Hours per Week i	n Mase			
	stetrics and Gynec	Code Hours per Week in Mass		
o o	rectics and synec	colody		
_		If OS, write specialty:		
		in the special of		
Are you American Specialty Boar		ES, Enter Codes:		
Code: 03 Board	of Obstetrics and	Gynecology Code:		
Code:		Code:		
Dwarf issues Name and the second				
Drug License Number(s) (if any) (b) How many DEA nos. do you have?		
	c) State (MA) #M			
I have completed my C.M.E. requ	irements in the two years preceding	g my renewal date: YES Waiver Requested		
You must till out a separate Walv	er Form. The waiver must be graph	led by the Board before your licenses will be seened by		
	sumentation of your CME's with your	r renewar application.		
- 9/90 - PB13971		[For Office Use Only: Waiver Granted Date: / /		

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 or	
List Insurer: Controlled Risk Insurance Co. Ltd (CRICU)	ne.
List Insurer: Controlled (45k Insurance Co. Ltd. (CR1CU) Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Ch. (ii) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: (ii) OTHERWISE EXEMPT:	eck one
(State how otherwise exampt):	
11. Current Hospital Affiliations (Supply the codes from Table 5 and place a check park next to those facilities where you have admitting privileges (ADI
Facility Code: D.7 1 (AP) Facility Code (0 4 (AP)	nr).
Facility Code:/_(AP) Facility Code:/_(AP) ### Facility Code:/_(AP) ###################################	
Adelicant Heading and the second	
Additional Hospitals at which you <u>previously</u> held privileges and other Health Care Facilities with which you were associated in the past 4 years. Facility Code: 998 Facility Code: 001 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 regident or distant to the contract of the	
b) If you are in a MA program, are you a ii) 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 <i>outpatient</i> care in MA? 20 hrs./wk, in MA.	
14. Principal Work Setting.	
a) What is your principal work setting? (See Table 6) 2. C	
Questions 15 through 22 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details on Form 15A. Refer to the instruction booklet for additional information.	
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)?	<u>No</u>
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?	
 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?	
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?	
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 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 country.	
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 filled any Massachusetts 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 certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.	
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 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 country.	state of the



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 re	d the instruction booklet.
· Copy this form and all attack	nents for your own records; you will need copies for credentialing and other purposes.
The December 11 shows 6	

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 MECEIVED		
	ng (see instructions) t wish to renew		
2. Other Prairie(3), it airy, under which you were necessed;	Corrections (BORAD PRINE GISTRATION		
3. A)Mailing/Home Address:	Other Name(s): NMEDICINE		
·	Mailing Address:		
ARTHUR G SPECTOR, M.D.	City/Town: State:		
· -	Zip: Country:		
B)Business Address: 57 BEDEORD STREET LEXINGTON, MA 02173-5409	Other Address: 1493 Cambridge St City/Town: Cambridge State: MA Zip: 62139 Country: 45A		
Home Phone: (781) 862 1404	Home: () Business: (617) 498 - 1660		
4. A) Date of Birth: C) Sex: M B) Lic. Issue Date: 07/13/89 D) SS#:	Date of Birth (M/D/Y): / / Sex (M/F):		
 A) Name of Medical School: Duke University School of Medicine 	Full Name of Medical School:		
B) Year Graduated: 1973 C) Degree: MD	Year Graduated: Degree (MD/DO):		
6. Specialty Code(s) (See Table 1)	Code(s) Hours Per Week in Mass		

If OS, Print Specialty:

7 0	A	D J - C	Marketon the process of the market
/. Current	American	Board of	Medical Specialties Certification (See Table 2)
			(500 14510 2)
Code:	OG	Code:	
Code.	04	Coue.	

Obstetrics and Gynecology

8. Drug License Numbers, if any:

A) Federal (DEA):

Code(s)

OBG

B) Massachusetts:

9. A) Other states where you are now licensed to practice

Hours per Week in Mass.

Abbr:

B) States where you previously were licensed to practice

Abbr:

Code:	Code:
Federal (DEA): Mass:	
Abbr:	
Abbr:	

Hours Per Week in Mass.

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

PF	INT NAME AND NUMBER: Last Name:	SPECTOR	Registration Number:_	38877		
10.	A. Current health care facilities at which you have of Table 3 and place a check mark next to those her Facility Code: 1 0 8/ (AP)	ith care facilities where you have admitting Facility Code: 42/(AP)	ovision of patient care. Supp privileges (AP). Facility Code:			
	Facility Code: 7 1/√(AP) If 999, print name(s):	Facility Code: 4 9 6/ (AP)	Facility Code:	_/_(AP)		
	B. Additional health care facilities at which you (See Table 3)	previously held privileges or with which you	were associated in the past t	wo (2) years.		
	Facility Code: Facili					
1).	My medical malpractice insurance is covered by a)	✓ Insurance Carrierb) Letter of	of Credit			
	Alternatively, indicate as follows: I am register	ing with Active status but I am not covered by	y medical malpractice insura	nce because		
	I am (check one) a) Not involved in d					
	Please explain exemption:					
	Are you currently in a post-graduate training progra		check one)	/es ⊠No		
13.	A. What is your principal work setting? (See Table					
	B. Care of patients in Massachusetts (see instructio		25			
	Average weekly hours involved in:		-			
	What is the approximate percentage of your	patient care hours in primary care? // 9	6			
\mathbf{p}	ARTA					
<u>det</u>	estions 14 through 22 refer to the past two (2) ails on Form R for all YES answers except for initions.	years only. Check either YES or NO r question 22. Refer to the instruction	(NOT N/A) to each ques booklet for additional in	tion. Provide formation and		
	THE PAST TWO (2) YEARS:			YES NO		
14.	CLAIMS MADE: Has any medical malpractice che adjudicated, whether or not a lawsuit was filed in rel		en finally settled or	I I I I I I I I I I I I I I I I I I I		
15,	CLAIMS RESOLVED: Has any medical malpracotherwise resolved, whether or not a lawsuit was file		en settled, adjudicated, or			
16.	Has any lawsuit, other than a medical malpractice su professional conduct in the practice of medicine, bee	it, which is related to your competency to pra in filed against you or been settled, adjudicate	ectice medicine, or your ed or otherwise resolved?			
	Have you been charged with any criminal offense, o					
18.	Have you been formally charged with or disciplined governmental authority, health care facility, group p	for any violation of the rules, by-laws or stan ractice or professional society or association?	dards of practice of any			
19.	Has your privilege to possess, dispense or prescribe denied or restricted by any state or federal agency?	controlled substances been surrendered to or s	suspended, revoked,			
20.	Have you withdrawn an application for a medical lic	ense or been denied a medical license for any	reason?			
21.	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 preced	ing your renewal date (see instruction bookle	y?	1		
	Waiver requested (waiver form due 30 days prio	r to date of license expiration). Training P	rogram exemption	i		
See	Instructions for CME requirements. Do not sub	mit documentation of your CMEs with y	our renewal application.			
	RENEWAL APPLICATION CONTINUED	-	• • • • • • • • • • • • • • • • • • • •	VERED.		
Ot						
oign	ature /WMW G. Jufw v	W.	Date:	1 48		
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Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02:11

Physician Lapsed License Application, Page 1 of 2 Board Use Only: Renewal Date Ón. D.E. important: . Read the accompanying instructions in their entirety before completing this form. Do not o iniportant teak to an employee, as false statements on this form can result in disciplinary action. . Print legibly or type your answ . 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 aignature. Make a copy of this form and all attachments for your own records—you must give hospitals and other health oare 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 Massachusette. 1. a) Name (LAST:) Spector 1. b) Other Name(s), if any, that you were ever licensed under; 2. a) Address (Malling):_ 2. b) Address (Home): Same 2. c) Address (Business):_ 2 d) Telephone (Business): (8 0 2-) 2 2 3 - 6 1 2 3 Extension_ 2. e) Talephone (Home) (Optional): 4. Sex: MALEX_ FEMALE_ 5. Social Beoutity No. (Optional): 3. Date of Birth (MO/DA/YR): 6. a) Medical School Code (See Table 1): N C 007 #99999, write Name: 6. b) Year Graduated: 1973 B. c) Degree: MDX DO 6. d) Country: U.S. X Canada Code If Other (See Table 2): ____ #999, write Name: Work Setting (Circle and Indicate Percent(%) of Practice Time): 20 15 Private Office 20 Partnership/Group Practice 10 Hospital 25 Clinic 30 Mental Health Center 35 Numbro Home 40 HMO Facility 45 Educational inetitution 50 Medical Society 99 Other 50 Plant/Commercial Setting 55 Government Fedility 8. Professional Activity (Circle and Indicate Percent(%) of Professional Time): S. b) Mass. Lin. (saus Date 20 Practice involving Direct Patient Care (see your wall certificate) 10 Resident or Fellow 40 Medical Teaching (MO/DA/YR): 30 Administrative Activities 50 Medical Research **DE** Other 9. Specialty Code (See Table 3): O B G Percent of Practice Time: 100 % Specialty Code: Percent of Practice Time: If OS, apacity: _ ...NA 10. a) Are you American Specialty Soard Certified? (Y/N) Y 10. b) if YES, circle which Board(s): Board of Plastic Surpery Board of Nuclear Medicine Board of Allergy & Immunology Board of Obstetrice & Gynecology PΜ Board of Preventive Medicine Board of Anesthasiology Board of Ophthalmology Board of Psychiatry & Neurology Board of Colon & Rectal Surgery PΝ Board of Radiology Roard of Orthopedic Surgery Board of Dermatology OS Board of Otolaryngology Board of Surgery Board of Emergency Medicine OT Board of Thoracic Surgery Board of Family Practice Board of Pathology Board of Urology Board of Internal Medicine Board of Pediatrics Board of Neurological Surgery Board of Physical Medicine & Rehabilit 11. a) Hospitals at which you have gurrantly effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each (See Table 4.) 9 9 8 20 Act print Facility Code: Facility Code: Facility Code: Feolity Code: Facility Code: ____ # 899, 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. Feelity Code: 998 × 3 Facility Code: O 1 4 Facility Code: 07 | Facility Code: 069 # 999, write Name(s): I hereby cartify that if requesting INACTIVE status, I will not practice medicine in Massachusetts. Pursuant to M.G.L. c.478, I will not charge to or solvest from a Medicare beneficiary more than the Medicare reasonable charge for my services. Pursuant to M.G.L. e.82C 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 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. 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.: 3	887
12. a) Other States where you are now licensed to practice (Abbreviale): 12. b) States where you previously were licensed to practice (Abbreviale): MA CT	
13. I am applying to be registered with the following status: ACTIVEX: INACTIVE INACTIVE INACTIVE, answer questions 14. a) through the plant of the plant of the of residency, or check water.) Category is here. (Fig. hrs., (Risk-Management: 6 hrs.): Residency Program In: : Walver Requested X	ii:
14. b) My medical malpractice insurance is covered by INSURANCE CARRIERX LETTER OF CREDIT, if applicable, check one and ident name. Insurer:PHICO	am not
14. c) Percent of Practice Time in Massachusetts: ** % 14. d) Have you practiced medicine actively and regularly since your license ispaed in Massachusetts? ** (Y/N) ** If No, please attach a lister of explanation.	
Questions 15 through 17: Check either YES or NO (not N/A) to geal question. Provide details on Form 18A, attached.	
15. Has any medical malpractice claim been made against you on or after Jan. 1, 1978 (whether or not a lawsuit was filed in relation to	
16. Have you, at any time, been a defendant in any oriminal proceeding other than a minor traffic offense?	
 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, state or local)? 	etional.
If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.	
Ovestions 16 - 24: Check either YES or NO (not N/A) to each question. Provide details in the next section.	*****
18. Hiss your privilege to occase of spaces or prescribe sensitive as between the control of the	No
any firme?	*
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 liness 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 deriled 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

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6	A.	1989-	1991 Physicia	n Registrat	ion Renewal App	lication,	Page 1 of 2	021	828
Board Use Onl Registration N		Fee	Renewal Da	9	9 101112 13 24				
Registration N	ARTHUR E	\$150	05/24/90	3-1234E	OHIGH.	18 19 20 A	M.R. Pr. Bk. Ch. D.E. Fl.	8 5	22/20 24/1
Important:					S	\$			
form can resu , Print legibly or . Answer all non- . Sign the renew . Make a copy o . Enclose the \$1	al application at ti f this form and ali	ction. he (<u>front and</u> he bottom o attachment means of a	<u>f back</u> of form) or f page one and fi s for your own re- cartifled check,	empletelyIt le ii in the numbe cordsyou mus money order or	not adequate to statu r of attached pages in t give hospitals and of personal check made	e that the B the paragra ther health o payable to	oard already h ph shove the si are facilities co the Commonw	ignature. ples for credentialin ealth of Massachuse	g purposes. Its.
	ne(s), if any, that y					121	V		
2. a) Address (A		on well as	or terational filtra	-					
Z. B) MIGHES (N	manneng):			-					
2. b) Address (H	iome):								
2. c) Address (B	usiness): 114	Walth	m MA	02173					
o al Valantino	(Ounterpart): (fr	2107	2 / U A L	Enterplant	2, e) Telepho	na (Harra)	(Ontional)		
		LIXL	r-1303	extension	Z, e) relupno	ne (Prome) ((Optional):		
3. Date of Birth					EMALE				
					ne:				
	uerted: 1973				_				
6. d) Country: i	J.S Canada_	Code i	Other (See Tabl	e 2):	# 999, write Name:				
10 Hospit 25 Clinic 40 HMO I		to Percenti 162% 13 %	15 Priv 30 Mer 45 Edu	ne): ate Office stal Health Con cational institu at/Commercial	tion %	35 50	Partnership/G Nursing Home Medical Societ Other		25% % %
us govern		~	00 114	ny commercial	a	95	Oliver		
10 Reside 30 Admin 50 Medic	Activity (Circle and int or Fellow istrative Activities at Research	10	40 M 40 M 6 99 O	actice involving edical Teaching ther	g Direct Patient Care 9	9	6	8. b) Mass. Uc. la (see your <u>wall cor</u> (MO/DAYR): 7 * Neven gol	Hicate)*
If OS, specify:					Specialty Code:		rcent of Practic	e (Ime:%	
			-		, circle which Board(s,				
A B CRS B D B EM B FP B	oard of Allergy & i oard of Ariesihesi oard of Colon & R oard of Dermatold oard of Emergend oard of Family Pro oard of Internal M oard of Neurologic	piogy lectal Surge lgy ly Medicine actice edicine	ry OP OS OT PA PE	Board of Or Board of Or Board of Or Board of Or Board of Pe Board of Pe		y PM PM R S TS U	Board of Board of Board of Board of	Preventive Medicine Psychiatry & Neurok Radiology Surgery Thoracic Surgery	Pgy
(See Table					alth Care Facilities wi	th which yo		d; Percent of Practic	
# 999, wri	te Name(s):								
(See Table Facility C	ode:998	Fa	cility Code: 9	8 Facilit	Health Care Facilities by Code: 998	Facility Co.	de: <u>998</u>	•	•
					edicine in Massachu				
					eneficiary more than that, to my best kno law. Note: This app				
					form-front and back				•
M	1.11		< 1	/				***	. 9.
Signature:		سلاكم	Circle	788	E MANAGER ZIOSE)			Date J CC	170

Massachusetts Board of Registration in Medicine 1989-1	991 Renewal Application, Page 2 of 2
FIII in name and number. Physician Last Name: SPECTOR	Registration No.: 3 8 8 2 7
12. a) Other States where you are now licensed to practice (Abbreviate): Y.T.	
12. b) States where you previously were licensed to practice (Abbreviate): 💪 T	
13. I am applying to be registered with the following status: ACTIVE V	INACTIVE # ACTIVE, answer questions 14, a) through c). # WACTIVE, answer question 14, b) only.
The state of the s	as follows: (Fill in # of hours or type of residency, or check waiver.) idency Program in:
14. b) My medical majoractice insurance is covered by INSURANCE CARRIER LETTER insurer: Controlled Risk Engages Co. Ltd. Institution issuing Letter of Other adversarial insurers and insurers to the covered to the control involved in direct/indirect patient care. OTHERWISE EXEMPT	red by medical majoractice insurance because I am (Check one)
14. c) Percent of Practice Time in Massachusetts: 100%	
Questions 15 through 17 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to	each question. Provide details on Form 15A, attached. Yes No.
Has any pending or new medical malpractice claim been made against you (whether or re	of a lawsuit was filed in relation to the claim)?
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 t against you by any governmental authority, hospital or other health care facility, or profess national, state or locall?	3card regulationsSee Instructions) been taken slonal medical association (International,
If you answered "YES" to question 15, 16, or 17 provide	
}	*********************
Questions 18 through 24 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to g	
 Hits your privilege to possess, dispense or prescribe controlled substances been suspended have you been called before or been warned by this state or any other jurisdiction including 	id, revoked, denied, restricted, surrendered, or g a federal agency?
 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 impalted your ability to practice medicine or to	function as a student of medicine?
21. Have yo. 'an organic iliness 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?	
4. Have you been depled recertification by one or more specially boards? # VES ## Reserve	b-

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

38877 ACTIVE \$250.00 05/24/96 \$25.00	-
Mailing Address: ARTHUR G SPECTOR, M.D.	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 a 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 - 	and may affect your The Office Codes And You will need comes for
See instructions on detachable coupon at bottom of this page	Births:
Pre-Printed Information	Corrections of 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	Name Address.
5 a) Other states where you are now heensed to practice (Abbr) VT b) States where you previously were heensed to practice (Abbr) CT	
6. Specialty Code(s) (See Table 1) Code Hours per Week m Mass OBG 44 Obstetrics and Gynecology	If OS, print specialty
7 If you are currently American Specialty Board certified, enter codes (Second Code Code 8 Drug heense number(s), if any a) Federal (DEA) b) Massachusetts	Code Code Federal (DEA)
O Activity Status I am applying to be registered with the following status I hereby certify that if requesting inactive status, I will not practice:	

PRINT NAME AND NUMBER: Physician Last Name Spector Registration Number 38877 10 a) Current health care faculary(ses) 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
b) Additional hospitals at which you previously neld privileges and other health care facilities with which you were associated in the past 2 years (See Table 3) Facility Code
b) Additional hospitals at which you previously neld privileges and other health care facilities with which you were associated in the past 2 years (See Table 3) Facility Code
Facility Code
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, check one List Insurer RICO Atternatively, 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 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) 2. O 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? ii) How many hours per typical week are you currently involved in inpatient care in Mass? (See instructions for definition of primary care) Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Prov. de 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: 14. CLAIMS MADE: Has any medical malpractice claim been findle 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?
Atternatively, indicate as follows: I am registering with ACTIVE stains, 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 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) (b) Care of patients in Massachusetts (See instruction booklet.) (c) How many hours per typical week are you currently involved in outpatient care in Mass? (d) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care) 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: (CLAIMS MADE: Has any medical malpractice claim beaut made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
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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 filled 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 hability insurance provider?
22 Have you been diagnosed with or do you have a medical condition which innits 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
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your accense vill 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 Wedlears beneficiary more transition was the Wedlears reason and a charge -
 Pursuant to G.L. c. 62 C, sec. 49A, I cereby certify under the pairs and penalties of perjury that, to the best of my knowledge and bell it have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This and required under law. NOTE: This and required 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 chadren as "experied of GL. c. 119, sec. 51A.
I hereby certify under the pains and penelbes of perjam for all information or this form and Portes R-Land R.C To. Stenature Onto Date 5 19.96

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Staple Check Here

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 Fe		Correction of Mahling Address:
-	Mailing Address:	Address (Mailing)	
	- TAUY S SHECTORY	City/Town State Country Code (See Ta	ble 1)
<u></u>	rections: Staple check to bottom of form. Add late fee if necessary		48077
•	Questions: Staple check to bottom of form. Add late fee if necessary Questions 1-8 include information from Board files. Please correct as no provided on the right hand side of the page. Before proceeding, please read the instruction booklet. Some questions Make a copy of this form and all attachments for your own records for credentialing and other purposes. The Board will charge a fee for extending the S250 00 renewal fee by means of a certified check, money of payable to the Commonwealth of Massachusetts.	are optional you will need copies ach copy it provides	For Office Use Only M.R. MAY 1 2 1994 Pt. Bk/D.E.
Pr	e-Printed Information	Correcti	ons of Pre-Printed Information
1.	Other name(s), if any, under which you were heensed		
2	a) Address (Home) b) Address (Business).	City/Town State: ADV Country Col. Address (Busmess) City/Town	Zip If 999 print Country If 999 print Country
	.:K1 at0 / A 32173	•	
4	Date of Birth: Lic Issue Date [7/1]/[3] SS# Telephone Number Home Business (5172.60-273: (6172.562-146-4) Name of Medical School.	Lic Issue Date (M/D/Y Telephone Number Home ()	
		Year Graduated:	Degree (MD/DO)
	Year Graduated: 3 Degree. 7		Degree (MD/DO)
5	a) Other states where you are now hoensed to practice (Abbr) v 7 b) States where you previously were licensed to practice (Abbr) 07		
		Code	Hours per Week in Mass
6	Specialty Code(s) (See Table 2) Code Hours per Week in Mass UDSTETRICS 770 C/Pettlo	If OS, print specialty	
	a) If you are currently American Specialty Board Certified, enter Codes Code: Code		Code Code
	b) If you previously were American Specialty Board certified, but are no please enter codes of prior certification (See Table 3) Code Code Drug License Number(s), if any a) Federal (DEA) b) State (MA)	longer,	Code Code Federal (DEA) State (MA)
	I have completed my CME requirements in the two years preceding my a You must fill out a separate Warver Form. The warver must be granted to CME requirements. Do not submit documentation of your CMEs with your	y the Board before your	No, waiver requestedhorizonal for

PRINT NAME AND NUMBER: Physician Last Name SPECTOR Registration Number 3887/
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 materiactics insurance is covered by (a) INSURANCE CARRIER or (b) LETTER OF CREDIT If applicable, check one. List Insurer: Lontrolled Risk Insurance to Ltd (CRICE)
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 Affihations. 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)
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 ms/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?
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?
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 local denied a medical license for any reason?
or restricted by any state or federal agency? 19 Have you withdrawn an application for a medical license or local 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?
or restricted by any state or federal agency? 19 Have you withdrawn an application for a medical license or local 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?
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or restricted by any state or federal agency? 19 Have you withdrawn an application for a medical license or local 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 hability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?
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or restricted by any state or federal agency? 19 Have you withdrawn an application for a medical license of them 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? 4. 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. 4. 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 filled 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.



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

2 38		
Registration No. Status Fee 38377 ACTIVE \$150	Renowal Date	For Office Use Only
or. ARTHUR G SPE	05/24/92	MR
DI ARTHOR G SFE	~~~	MR Pr Bk PASM 12
	- 62 / 1	Cn
		DE
Directions.	- Programme	
• Questions 1-7 include information from Board i	files Please codes	necessary
 Before proceeding, please read the instruction 	booklet 2	
Answer all non-optional questions completely	(The instructions s	vision questions are optional.) Dist give health, sare facilities copies for credentialing purposes. The Board charges.
\$3 00 plus postage for each copy furnished	or your own records—	post give health ware tackities copies for credentialing purposes. The Board charges
Enclose the \$150 00 renewal fee by means of a	a certified check, mone	der or personal check made payable to the Commonwealth of Massachusetts.
Activity Status:	/	CAAR
I am applying to be registered with the following s		_ inactive FUR COOK
I hereby certify that if requesting ins	ctive status, I will not p	ractice medicine in Massachusetts.
Pre-Printed Information		Inactive POOR CRICILL COPY Corrections of Pre-Printed Information
Pre-Filling illionission		Corrections of Pre-Printed Information
1 Other Name(s), if any, under which you were licensed		Name
2 a) Address (Home) 2 b) Address (Business) 11 + LTHAR STREET		Address
		City/Town
		State Zrp
		Country Code(if 999 write Country)
		Address
		City/Town
LIXINGTON, MA 02173-		State Zip Country Code (if 999, write Country)
		(if see, while Country)
3 Date of Birth Sex M		Date of Birth (M/D/Y)/Sex (M/F)
Lic Issue Date 37/13/69 SSN#		Lic Issue Date(M/D/Y)/SSN #
Telephone Number		
Home Business	ž.	Home () Business ()
	362-1404	
4 Medical School Code N C 0 0 7 Year Gra	duated 73 Degree N	
Name of School	- 4 4	If 99999, write School
Duke University School 5 a) Other States where you are now licensed to		
b) States where you previously were licensed to		
	, (, . 1	
Specialty Code(s) (See Table 3)		
Code Hours per Week in Mass		Code Hours per Week in Mass
CLC 💢 Obstetnic	es and Gyneco	10 44 TO 44
Û		
		If OS write specialty
7 a) Are you American Specialty Board Certified?	OWN V ZEV KVD	0. 5-1-0-1-
	stetrics and	
Code	stetrics and	Synecticgy Code
3000		VVVI
B Drug License Number(s) (if any) [optional] a)	Federal (DEA)	b) How many DEA nos do you have?
	State (MA) #M.	-1 in it is a fact that it
9 I nave completed my C M E requirements in	the two years assessed as	thy renewal date VES / We yor Revulanters
(You must till out a secarate Walver Form Tr	ne walver must be grante	d by the Board before your license will be renewed. See Instructions for CME.
requirements. Do not submit documentation	of your CME's with your	renews! application
20M PAGE PRICES		[For Otton Lan Ones, Manua Constant