

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 checkmark next to those facilities where you have admitting privileges (AP))

Facility Code 0711 (AP) ☒

Facility Code 042 (AP) ☒

Facility Code \_\_\_\_\_ (AP)

Facility Code \_\_\_\_\_ (AP)

Facility Code \_\_\_\_\_ (AP)

Facility Code \_\_\_\_\_ (AP)

If 999, write Name(s) \_\_\_\_\_

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

Facility Code 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? 29 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.47E, 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. 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 27A.

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

Signature

*John G. Spector MD*

Date

5.15.92



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

## Physician Registration Renewal Application

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

- Remit \$400.00 for renewal fee (non-refundable).
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

1. Current Status: Active Registration No.: 38877 Renewal Date: 05/24/2004

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:

Please make corrections (print)

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

A) Mailing/Business Address:

3. ARTHUR G SPECTOR

B) Home Address:

Home Phone:

Business Phone:



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: ( )	
<b>PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.</b>	

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 8 50 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.)

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

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

Facility Code: 532/98 (AP) 98 % Facility Code: 42/ (AP) 1 % Facility Code: / (AP) %  
Facility Code: 71/ (AP) 0 % Facility Code: 996/ (AP) 1 % Facility Code: / (AP) %  
If 999, print name(s):



# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector

License No.: 38877

*MS*

05/11/06 32

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## PART A

1) Current Status: Active

Renewal Due Date: 04/26/2006

Birth Date:

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

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone:

☐ Check here to change this address

2c) BUSINESS ADDRESS

1493 CAMBRIDGE ST.  
CAMBRIDGE, MA 02421-8220

Phone: (617)665-2800

☒ Check here to change this address

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Board of Registration  
in Medicine

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

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

Home address cannot be a Post Office Box

Business Address: \_\_\_\_\_  
City/Town: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: 02139 Country: \_\_\_\_\_  
Business Telephone: (\_\_\_\_) \_\_\_\_\_

Business address cannot be a Post Office Box

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

4) Fax Number: 617-665-2891

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

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input checked="" type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector

License No.: 38877

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(See Renewal Instructions, page 4.)

**7) Drug License Numbers, if any:**

- a) Massachusetts:
- b) Federal (DEA):
- c) Federal (DEA) XS:

Please make corrections as necessary

**8a) Other states where you are now licensed to practice (Abbr.)**

**8b) States where you were previously licensed (Abbr.)**

VT CT

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

Principal Work Setting: Hospital

Change to: \_\_\_\_\_

Please enter the approximate number of work hours at your principal work setting: 60

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

No Affiliations ☐

Please enter the approximate number of work hours for each Health Care Facility below:

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		Approximate # Hours per Week
		Current	Change	
Cambridge Public Hlth Commission (The)	<input type="checkbox"/>	Active		60
Clinic Planned Parenthood	<input type="checkbox"/>	Active		2
Martha's Vineyard Hospital	<input type="checkbox"/>	Admitting		4
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 36 hrs/wk Change to: \_\_\_\_\_ hrs/wk

b) outpatient care 22 hrs/wk Change to: \_\_\_\_\_ hrs/wk

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

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

☐ **Insurance Carrier (complete below)**

Current Insurance Carrier: CRICO

Change to: \_\_\_\_\_

Policy dates: From 1 / 1 / 06 To 12 / 31 / 06  
(required)

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

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

Check one:

- ☐ Not involved with direct or indirect patient care in Massachusetts
- ☐ Government Employee Federal Tort Claims Act (FTCA)
- ☐ Otherwise exempt (Please explain): \_\_\_\_\_

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector

License No.: 38877

13) Do you perform any surgery in your office? (See Renewal Instructions, page 5.)

Yes No

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

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

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

YES NO

<p><b>14) CLAIMS MADE</b></p> <p>a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim?</p> <p>b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?</p>	
<p><b>15) CLAIMS PAID</b></p> <p>Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?</p>	
<p><b>16) OTHER CIVIL LAWSUITS</b></p> <p>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.</p> <p>a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?</p> <p>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</p>	
<p><b>17) CRIMINAL CHARGES</b></p> <p>a) Have you been charged with any criminal offense during this time period?</p> <p>b) Are there any criminal charges pending against you today?</p> <p>c) Have any criminal offenses/charges against you been resolved during this time period?</p>	
<p><b>18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?</b></p>	
<p><b>19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?</b></p>	
<p><b>20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?</b></p>	
<p><b>21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?</b></p>	

## 22) CME CERTIFICATION:

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

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector

License No.: 38877

## PHYSICIAN PROFILE

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

## CERTIFICATIONS

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

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

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

*Arthur G. Spector*

Date: 4 / 19 / 2006

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



# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector

License No.: 38877

## NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

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

☐ My current NPI is:

☐ I have personally applied for an NPI.

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

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

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

## HIPAA TAXONOMY CODES

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

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

2 0 7 7 0 0 0 0 X

Obstetrics & Gynecology

Provider Taxonomy:

Provider Taxonomy:

## NPI REQUIRED INFORMATION

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

Social Security Number:    -   -

State of Birth (if US): New York Country of Birth (if outside the US): \_\_\_\_\_

Gender: ☒ Male ☐ Female

## Penalties for Falsifying Information on the National Provider Identifier Application

18 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to \$500,000. 18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

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

Signature: Arthur G. Spector

Date: 4/19/2006

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



# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

## PART A

1) Current Status: Active

Renewal Due Date: 04/26/2008

Birth Date:

If you want to change your current status, please check one of the following boxes to indicate your new status:

Check only one: (See Renewal Instructions, page 3.)

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

### 2a) MAILING ADDRESS

Please make corrections (print)

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Country: \_\_\_\_\_

☐ Check here to change this address

### 2b) HOME ADDRESS

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_

Phone:

☐ Check here to change this address

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Board of Registration  
in Medicine

Home address cannot be a Post Office Box

### 2c) BUSINESS ADDRESS

1493 Cambridge St.  
Cambridge, MA 02139

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

City/Town: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_ Country: \_\_\_\_\_

Business Telephone: (\_\_\_\_) \_\_\_\_\_

Phone: (617)665-2800

☐ Check here to change this address

Business address cannot be a Post Office Box

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

4) Fax Number: (617)665-2891

Correct your E-mail and Fax Number below:

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

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

List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.
Board Name	ABMS or AOA
Certificate/Subspecialty	Delete?
Obstetrics & Gynecology	ABMS
Obstetrics and Gynecology	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>
	<input type="checkbox"/>

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

06/07/08 5:28

(See Renewal Instructions, page 4.)

**7) Drug License Numbers**

Corrections:

a) Massachusetts: \_\_\_\_\_

b) Federal (DEA): \_\_\_\_\_

c) Federal (DEA) XS: \_\_\_\_\_

Please make corrections as necessary

**8) Other states where you are now licensed to practice**

**9) States where you were previously licensed**

VT CT \_\_\_\_\_

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

List the names of all work sites in Massachusetts

(See above and description on page 4.)

Location  
(City or Town)

State

Delete?

Cambridge Public Hlth Commission (The)

Clinic

Martha's Vineyard Hospital

\_\_\_\_\_

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

Average weekly hours involved in: a) inpatient care 36 hrs/wk Change to: \_\_\_\_\_ hrs/wk

b) outpatient care 22 hrs/wk Change to: \_\_\_\_\_ hrs/wk

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

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

☒ Insurance Carrier (complete below)

Current Insurance Carrier: CRICO

Change to: \_\_\_\_\_

Policy dates: From 1/1/08 To 2/31/08

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt (Please explain): \_\_\_\_\_

**13) Do you perform any surgery in your Massachusetts office? (See Renewal Instructions, page 5.)**

Yes No

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

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

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

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

YES NO

<b>14) CLAIMS MADE</b> a) <b>NEW:</b> Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above). b) <b>PENDING:</b> Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?	
<b>15) CLAIMS CLOSED</b> Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?	
<b>16) OTHER CIVIL LAWSUITS</b> Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?	
<b>17) CRIMINAL CHARGES</b> a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?	
<b>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</b> a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?	
<b>19)</b> Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?	
<b>20)</b> Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?	
<b>21)</b> Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?	

## 22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
- b) If no, are you requesting a CME waiver? ☐ Yes ☐ No

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

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

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

# Massachusetts Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

## PART C

### Check One:

### PHYSICIAN PROFILE

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

### CERTIFICATIONS

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

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

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

*Arthur G Spector*

Date: 5/4/2008

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



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

Current Status: Active

License Expiration Date: 5/24/2010

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 1493 Cambridge St.  
Cambridge  
Massachusetts - 02139  
United States of America  
(617) 665-2800

3) Email Address:

4) Fax Number: (617) 665-2891

5) Specialties  
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
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8) Other states where you are now licensed to practice  
None Reported

9) States where you were previously licensed  
Connecticut  
Vermont

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Cambridge Public Hlth Commission (The)	



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

**Physician Name:** Arthur G Spector, M.D.

**License No.:** 38877

Clinic  
Martha's Vineyard Hospital

**11) Care of patients in Massachusetts**

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

**12) Medical Liability Insurance Information**

<b>Insurance Carrier</b>	<b>Policy Start Date</b>	<b>Policy End Date</b>	<b>Policy Type</b>
Controlled Risk Insurance Company of Verm	01/01/2010	12/31/2010	Claims made with tail coverage

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

**14) Claims Made**

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

**15) Claims Closed**

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

**16) Other Civil Lawsuits**

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

**17) Criminal Charges**

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

**18) Other Issues**

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

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

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

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



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

**Physician Name:** Arthur G Spector, M.D.

**License No.:** 38877

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- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?





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

**Physician Name:** Arthur G Spector, M.D.

**License No.:** 38877

**Compliance with Legal Responsibilities**

**Online profile:**

☒ I have reviewed my Physician Profile and confirm that the information is accurate.

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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

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



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

Current Status: Active

License Expiration Date: 5/24/2012

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 1493 Cambridge St.  
Cambridge  
Massachusetts - 02139  
United States of America  
(617) 665-2800

3) Email Address:

4) Fax Number: (617) 665-2891

5) Specialties  
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
---------------	---------------	------------------

8) Other states where you are now licensed to practice  
None Reported

9) States where you were previously licensed  
Connecticut  
Vermont

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
Cambridge Public Hlth Commission (The)	



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

Clinic  
Martha's Vineyard Hospital

**11) Care of patients in Massachusetts**

Average weekly hours involved in:

- a) inpatient care 26 hrs/wk  
b) outpatient care 32 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier

Controlled Risk Insurance Company of Verm

Policy Start Date

01/01/2012

Policy End Date

12/31/2012

Policy Type

Occurrence Policy

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

**14) Claims Made**

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

**15) Claims Closed**

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

**16) Other Civil Lawsuits**

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?  
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

**17) Criminal Charges**

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

**18) Other Issues**

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

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

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



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?
- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)

Yes



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

**Physician Name:** Arthur G Spector, M.D.

**License No.:** 38877

- 
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

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**Compliance with Legal Responsibilities**

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- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
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- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
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☒ Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

Current Status: Active

License Expiration Date: 5/24/2014

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 1493 Cambridge St.  
Cambridge  
Massachusetts - 02139  
United States of America  
(617) 665-2800

3) Email Address:

4) Fax Number: (617) 665-2891

5) Specialties  
Obstetrics and Gynecology

6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice  
None Reported

9) States where you were previously licensed  
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Vermont

10) Work Sites

List of all work sites in Massachusetts, including health care facilities (where you are credentialed), private office, clinics, nursing homes, etc

WorkSite	Location
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Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

Martha's Vineyard Hospital

**11) Care of patients in Massachusetts**

Average weekly hours involved in:

- a) inpatient care 26 hrs/wk
- b) outpatient care 32 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier

Policy Start Date

Policy End Date

Policy Type

Controlled Risk Insurance Company of Verm 01/01/2014

12/31/2014

Claims made with tail coverage

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

**14) Claims Made**

- a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?
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**18) Other Issues**

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

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

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



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Arthur G Spector, M.D.

License No.: 38877

- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?
- 22) Have you completed all CPD requirements (100 hours of CPD of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if you are renewing your license for the first time, please answer Yes)

Yes



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

**Physician Name:** Arthur G Spector, M.D.

**License No.:** 38877

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

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