

UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL APPLICATION FOR SENIOR ELECTIVE

Section I			university co	E
Student's Name NiNA	MARIE CARR	olt Medical:	School LIEGE BE	LCrivM
Mailing Address			Year 4th year	
				1
Elective(s) Desired:				•
1. FAMILY-MED-CU	TRAPMIMber -601	Dates Oct	- tr Nov Alternat	e
(2) GAN ONCOLOG	y Number 110	O Dates Oct	ov Nov. Alternat	e
			Al ternst	
Section II (to be completed. This is to certify the this institution and has be covered by personal 1	ted by school off	ficial at medic	al school where stude a student in good street indicated above.	ent is enrolle anding at He or she will
while at your institution	n.	Signature R. Dean of Title June Date	LAMBOTTE, M.L. The MEDICAL S	S. S. CHOOL_
Section III Your application for the Approved You will be expected to a control of the control	Not Apprepart to the following	lowing:	111	J. Finker
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CERTIFICATION OF POST-GRADUATE TRAINING

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had post-graduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

Kenneth C. Edelin, M.D.	Chief, Department of OB/GYN
Name	Title
hereby certify that NINA	MARIE CARROLL has served 21/2 year(s
of post-graduate training as	a RESIDENT in OBSTETTLIS + GYNELOLX Position Specialty
0 = 1000 4000	
at BOSTON CITY HOSPITA	L, BOSTON, MASS.
HOSPITAL	City State
This program is is not	approved by the ACGME or the RRC.
Dr. Canol pa	rticipated in this program from
June , 1983 to p	mesent, 1986 and was issued was not Month Year
issued a certificate as p	roof of completion of said training. (If not
issued a certificate, please	explain)
	,
physician was, to the best of	time of completion of the above training, this my knowledge, competent to practice medicine action outstanding or pending involving nim
er a	
or her.	\$ignature of Director
Hospital Seal	4-16-86
	Date
RETURN THIS FORMEDIRECTLY TO:	
	BOARD OF REGISTRATION IN MEDICINE 100 CAMBRIDGE STREET, ROOM 1507 BOSTON, MASSACHUSETTS 02202



5 15 5

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

Instructions: This Form E and the attached Form F must be sent to your medical school for completion by the Dean or other appropriate official and returned directly by the medical school to the Board's office address above. If you attended more than one medical school, this form may be duplicated and forwarded to each medical school at which you received academic credit.

To the Medical School: Please complete the enclosed forms in full and attach a complete and official copy of the applicant's medical school transcript showing courses completed and grades received. The completed forms and accompanying transcript should be returned directly to the address above. If you have any problems completing these forms, please attach a written explanation. Thank you for your cooperation.

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							THAN THIRT!
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	·		(Na:	me of	medical s	school)	-
dates	of instruc	tion, incl	iding month,	day	of month a	and year for	each year
to sho	w the numb	er of weeks	s, excluding	vaca	tions in e	each vear):	
	,		,				
FROM:				TO:			
	Month	Day	Year		Month	Day	Year
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	Month	Day	Year		Month	Day	Year
FROM:	October	1	1978	TO:	Ju1y	20	1979
	Month	Day	Year		Month	Day	Year
FROM:	October	1	1979	TO:	July	20	1980
	Month	Day	Year		Month	Day	Year
FROM:	October	1	1980	TO:	July	20	1981
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AND HA	AS RECEIVED	THE DEGREE	E OF M.D.	<u> </u>	ONJul	<u>y 20 </u>	
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	Sç	hool Seal)		019	177	
	()		ĺ		P. F	RANCHIMONT	
	<u> </u>					Name	
Date:	July 18		1985			Dean	
						Title	

To be completed only if you attended college outside of the United States, Canada or Puerto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION (to be completed ONLY by the Dean of the School)

			Date	May 5th		1983_
I hereby certify the a pre-medical cours	at <u>Miss CAR</u> se.	ROLL Nina		has cre	editably complete	ed <u>two years</u> of .
From Month	October		To Month	September	1978	Year
From Month	October	1978		July 1979	Dov	Year
School Seal			Dean School	Universi	ty of Liège	
	. Carlo	All Me	dical Graduat	es		
	VERIFICATION (to b	N OF MEDICAL e completed ON	INSTRUCT	ION AND GRA an of the School	ADUATION)	
			Date	May 5tl	<u> </u>	19_83_
I hereby certify the least three and one	atMiss e-half years of med	CARROLL Nin lical education.	.a		has creditable	y completed at
From	October 1	979	To Month	uly 1980	Dov) ecr
From	Daj. October 1	980	To Munit	uly 1981	20,	
Month	Day		ear Munth		Day	Year
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and has received to	he degree of <u>doc</u>	tor of mean		on <i>Iu1</i> _	<u> </u>	
from Univers	Surgery thum. 8 fm. 1 in 14.	and Accouch	nents			
School Seal	in the state of	a l		51	gnature of Dean	
If candidate has a	ittended offer ha		hool, additio	nal verification o	f medical instruc	tion is required.

To be completed only if you attended college outside of the United States, Canada or Pugrto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION (to be completed ONLY by the Dean of the School)

		Date			19
hereby certify that				has creditably co	mpleted two years of
pre-medical course.					
rom		To			
Month	Day	Year Mo	nth	Day	Year
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VFR	JEICATION OF	MEDICAL INSTRUC	TION AN	D GRADUATIO)N
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hereby certify Half				has cre	ditably completed at
east three and one-half OCTO					40
rom September	29	19 78 To		18	1978
Month En	nor NOar	Year Mo	July	Day 20	1979 rear
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rom October		/180 To	JN	1 17	1981
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and has received the de	/ (2)	on beliani	•	14 20,19	19 83
rom PACNETY	OR My dien	re or Univers			han
ichool Seal		-	- LANGER TOPP	signature of Dean	

If candidate has attended more than one medical school, additional verification of medical instruction is required.

THE COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE 100 CAMBRIDGE STREET, ROOM 1507 BOSTON, MASSACHUSETTS 02202

SWORN	STATEMENT	OF	THE	DEAN	OF	THE	MEDICAL	SCHOOL

medical school and more than one med: to each school at	is form should be c i returned directly ical school, this f which you received	to our office. orm may be duplicated academic credit.	If you attended ated and forwarded
I, P. FRANCHIMO			University of Liege(Belgium) lical School
hereby certify the	At CARROLL Nina Name of App	licant	was physically
present at this in	nstitution for the	first two years o	f matriculation in
medical school and	i that he/she succe	ssfully completed	at least two aca-
demic years, of not	t less than thirty-	two weeks in each	academic year,
including the fol	lowing courses of b	asic science stud	y:
	gross anatomy biochemistry pathology physiology	microbiology immunology pharmacology	
I further certify	that Nina Name o	f Applicant	successfully
completed an addi	tional two academic	years of not les	s than thirty-two
weeks in each acad	emic year, at this	institution of th	e following courses
of study:			
	· internal medicine · surgery · pediatrics	<pre>. obstetrics and . public health psychiatry</pre>	d gynecology & preventive medicine
All of Dr CAP	ROLL 's cli	nical ctudy use s	ommisted at the
	ls under the onsite		
	of the faculty of		
Area of Study	Supervisor Fa	culty Appointment	Hospital
Internal medicine	H. VAN CAUWENBERGE	full professor	Hôpital universitaire (Bavière)
Surgery	G. LEJEUNE	1)	n (baviere)
Pediatrics	F. GEUBELLE	11 51	n tt.
Obsterics/Gynecology	R. LAMBOTTE	11 11	и п
			continued

Area of Study	Supervisor	Faculty Appointment	FORM F CONTINUED Hospital
Preventive medicine Preventive medicine	J.M. PETIT J. BOBON	full professor	Hopital universitaire (Baviere)
All clinical stud	dy was completed	under my direct control	and approval.
All information of made under the	contained in this	s document represents a	true statement
Date:	19 85	59, boulevard de la	Constitution

4020 LIEGE

Additional comments:

THIS FORM MUST BE RETURNED DIRECTLY TO THE BOARD AT THE ADDRESS ABOVE

SWORN STATEMENT OF THE DEAN OF THE MEDICAL SCHOOL

more than one me	nd returned dire dical school, th	be completed only by the ectly to our office. If his form may be duplicate	you attended
to each school a	-	eived academic credit.	
I. a. Examina	<u>, </u>	Dean of Name of Medi	FACULTE DE MODEUME
Name of	vean	Name of Medi	THE LANGE WEEK THUTION, 50
hereby certify the	Name of	Y:wa Applicant	s buastcaria.
present at this	institution for	the first two years of	matriculation in
medical school as	nd that he/she s	successfully completed a	t least two aca-
demic years, of no	ot less than thi	rty-two weeks in each a	cademic year,
including the fo	llowing courses	of basic science study:	;
	gross anatomy biochemistry pathology physiology		
I further certify	v that Nina N	Marie Carroll	uccessfully
	Na	me of Applicant	
completed an add:	itional two acad	emic years of not less	than thirty-two
weeks in each aca	demic year, at	this institution of the	following courses
of study:		,	
	internal medi surgery pediatrics	cine obstetrics and public health & psychiatry	gynecology preventive medicine
All of DrCar	roll 's	clinical study was com	pleted at the
		site supervision and ev	
following members	of the faculty	of this medical school	:
Area of Study	Supervisor	Faculty Appointment	Hospital
. Internal Medicine		ge full professor	Hõpital universitaire
Internal Medicine	H. CulbertusA. Mutsers	Associate professor	Hôpital Val D'Or
Internal Medicine		\$1 P	Hôpital de Bruyères
Surgery	D. Honore	full professor	Hôpital universitaire
Surgery	P. Carlier	clinical instructor	P
Surgery	M. Lifrange	\$1 TI	continued Bruyeres
Obstetrics and Gyn	R. Lambotte	full professor	Hôpital universitaire
Pediatrics	R. Jadoul	clinical instructor	Hôpital de Dinant
/ Pediatrics	A. Mattiva	32 11	Hopital des Anglais
/ Psychiatry	D. Luminet	associate professor	Hôpital universitaire
	J. Bobon	full professor	

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I HERE	BY CERTIFY	THAT	Nina Marie (Carroll		HAS C	OMPLETED AND
			(Name of A	pplica	int)		
ATTENL	DED FOR	BIX ACAD	EMIC YEARS	OF INS	TRUCTION, OF	NOT L	ESS THAN THIRTY-
TWO WE	EEKS IN EACH	ACADEMIC	YEAR AT U	iversi	ty of Liege, B	elgium	(Give exact
			(N	ame of	medical sch	ool)	
dates	of instruct	ion, incl	uding month	, day	of month and	year	for each year
to sho	w the numbe	r of week	s, excludin	g vaca	tions in eac	h year) :
FROM:	October	1	1977	TO:	July	20	1978
	Month	Day	Year		Month	Day	Year
FROM:	October	1	1978	TO:	July	20	1979
	Month	Day	Year	**	Month	Day	Year
FROM:	October	11	1979	TO:	July	20	1980
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	Month	Day	Year		Month	Day	Year
FROM:	October	1	1981	TO:			1982
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AND HA	S RECEIVED	THE DEGRE	e ofM.	D.	ON July	20/	<u>83</u> ·
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	7	198H				Name	
Date:	1 7		_19			Title	Nean
						CITIC	



THE COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

Application Fee: \$275.

EX EXAMINATION APPLICATION PLACE USE Application # 58146Filed: Date of Issue: Castificate # PLEASE PRINT OR TYPE Date: SEPREMBER 27, 1984 Name NINA MARIE Mailing Address: Date of Birth MASS Place of Birth NEW BEDFORD Name on Birth Certificate Nila mane Canadi Phone # Pre-Medical Education Recurry

I Attended 6 years of
School 7 year medical School profrom School UnivERSITY of Liebe MEDICINE Dates Attended Oct. 1977 - July 1979 Dates Attended October 1977 - July 1983 POSTGRADUATE TRAINING: (Include all internships, residencies, fellowships, etc.) Position: RESIDENT OB GUN Hospital: BOSTON City HOPAN FROM: 7/1/83 TO: Present Position: _____ Hospital: _____ FROM: _/ _/ _TO: _/_ Hospital: Position: MEDICAL CURRICULUM VITAE: (If applicable) ma List all other states where you are or have been licensed more 1. Was any medical license ever revoked, suspended or cancelled? Have you ever been denied a medical license? 3. Have you ever been denied the privilege of taking an examination? 4. Have you ever failed an examination before a State Medical Board? 5. Hasayour privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? 6. Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff? 7. Have you ever been a patient for the treatment of mental illness? 8. Have you ever been under treatment for drug addiction or alcoholism? 9. Has a judgement ever been returned against you in a malpractice suit? 10. Have you ever been convicted of any criminal offense other than minor traffic offenses?

Massachusetts Board of Registration in Medicine Physician Profile

NINA M. CARROLL, MD

This Profile is not available for public release until 01 April 97

Physician Information

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

Dr. CARROLL has been fully licensed in Massachusetts: 10 years

Accepting new patients? Yes

Accepts Medicaid? Yes

Primary work setting: Private Office

Business address: 25 BOYLSTON STREET

CHESTNUT HILL, MA 02167-Phone: 617-277-3119

Translation services available: None

Insurance Plans Accepted PILGRIM HMO Blue

Hospital Affiliations

AETNA Beth Israel Hospital Mount Auburn Hospital us

BCBS (Indemnity) Tufts STATE HANCOCK

Other Plans CIGNA PRILCARE

II. Education & Training

Faculte de Medecine, Universite de l'Etat a Liege Medical School:

Graduation Date: 1983

Post Graduate Training:

07/01/83 - 06/30/84 BOSTON UNIV MED CTR 07/01/84 - 06/18/87 BOSTON UNIV MED CTR INTERNSHIP: OB/GYN RESIDENCY: OB/GYN

III. Specialty

Gynecology ABMS Board Certified: Obstetrics & Gynecology

IV. Honors and Awards

This physician has reported no awards.

V. Professional Publications

GYNECOLOGICAL INFECTIONS AND SEXUAL PRACTICES. (IN PRESS)

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



BOARD OF REGISTRATION IN MEDICINE

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW (Fee of \$25.00 must accompany application-no currency or personal checks)

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.
SECTION A: Sworn statement to be completed by applicant. Please type or print. Name: NINA MARIE CARROLL Mailing Address: First Middle Last Date of Birth:
Pre-medical School: Coston University Medical School: Faculty of med. University of Lies. Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? 84392— (give number, if applicable YES NO
1. Have you ever had any medical license revoked, suspended or cancelled? 2. Have you ever been denied a medical license? 3. Have you ever been denied the privilege of taking an examination before any State Medical Board? 4. Have you ever failed an examination before a State Medical Board? 5. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? 6. Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff? 7. Have you ever been a patient for the treatment of a mental illness? 8. Have you ever been under treatment for drug dependency or alcoholism? 9. Has a judgement ever been returned against you in a malpractice suit? 10. Have you ever been convicted of any criminal offense other than minor traffic offenses? 11. If you answered YES to any of the above questions, please provide a detailed statement. 12. In the your ever had not before a State Medical Board? 4. Have you ever been warmination before a State Medical Board? 5. In the your ever had not prescribe controlled substances or prescribe controlle
SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment. This certifies that has been appointed to the position of
in (Name of Hospital) peginning and ending
(yes or no) If yes, is this program ACGME or RRC accredited? (yes or no) If yes, is this program ACGME or RRC accredited? (yes or no) If the program is not accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited esidency training program in the applicant's specialty? (yes or no)
IGNATURE OFFICIAL CAPACITY DATE
LL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES F PERJURY.



DIEBLEN TOTAL CLACK 4630 THE COMMONWEALTH OF MASSACHUSETTS CENTATEd Copy Extrust centificate

APPLICATION FOR LIMITED REGISTRATION AS INTERN MEDICAL OFFICER OR FELLOW (Fee of \$25.00 must accompany application-no currency or personal checks)

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HELD	IN I	MASS	ACH	JSET	TS,	SUB	MIT	A N	OTA	RIZ	ED F	тон	OCOF	Y OF	THE
													F Th	IE ST	ANDARD
ECFMG	MU:	ST B	E St	JBMI	TTED	WI	TH I	FIRS	T F	RENEI	WAL.				

FOR OFFICE USE Date Received _6/5/86 Certificate # 4

SECTION A: Sworn statement to be completed by applicant. Please type or print.
Name: NINA MARKE CARROLL Mailing Address:
First Middle Last
Date of Birth:
Pre-medical School: Bossa university Medical School: Frenchy or MEDICINE BELGIN
Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? 87735
Have you ever held a previous LIMÎTED REGISTRATION IN MASSACHUSEITS? <u>\$7735</u> (give number, if applicable
1. Have you ever had any medical license revoked, suspended or cancelled?
2. Have you ever been denied a medical license?
3 Have you ever been denied the privilege of taking an examination before
any State Medical Board?
4. Have you ever failed an examination before a State Medical Board? 4. Has your privilege to possess, dispense or preserate controlled sub-
stances ever been suspended or revoked in this/state/or any other? 5.
6. Have you ever been warned, censured, had your privileges restricted or
been requested to withdraw from a hospital staff? 7. Have you ever been a patient for the treatment of a mental liness? 7.
8. Have you ever been under treatment for drug dependency of alcoholism?
9. Has a judgement ever been returned against you in a marpractice suit?
10. Have you ever been convicted of any criminal offense other than minor traffic offenses?
If you answered YES to any of the above questions, please provide a detailed statement.
SIGNATURE OF APPLICANT: Niva Cann M.D. DATE: 5/23/86
SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital
in which the applicant has received an appointment.
The second of th
This certifies that NINA MARKE CAMOU has been appointed to the position of PGY-4
Senion RESDONT in Bosson City Hospital (Name of Hospital) beginning July 1, 1980 and ending July 30, 1987
(Name of Hospital)
beginning July 1, 1986 and ending June 30, 1987
Is the purpose of this application participation in a training program? YES (yes or no)
If yes, is this program ACGME or RRC accredited? 15 (yes or no) If the program is not
so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? WA (yes or no)
Make a levele
Maxine Kessler, Director Physicians Services 5/27/86
SIGNATURE OFFICIAL CAPACITY DATE

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

THE COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE

pprone 6.30.85

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW (Fee of \$25.00 must accompany application-no currency or personal checks)

FOREIGN MEDICAL GRADUATES MUST SUPPLY ECFMG CERTIFICATE. IF NO PREVIOUS LIM HELD IN MASSACHUSETTS, SUBMIT A NOTARI INTERIM ECFMG CERTIFICATE. A NOTARIZE ECFMG MUST BE SUBMITTED WITH FIRST REN	ITED LICENSE HAS BEEN ZED PHOTOCOPY OF THE D COPY OF THE STANDARD	FOR OFFICE USE Date Received 87435 Certificate # 87374 By: Form of Fee: 25 MO
SECTION A: Sworn statement to be composited by the statement to be composi	oll Mailing Address: t Medical School:	ETTS? S4392
1. Have you ever had any medical lice 2. Have you ever been defied a pedica 3. Have you ever been defied a pedica 4. Have you ever failed an amination 5. Has your privilege theory, disconness ever been warned been requested to withdraw from the sure you ever been a patient for the sure you ever been under the sure been requested to withdraw from the sure you ever been under the total the sure you ever been under the sure of the sure you ever been convicted of an traffic offenses? If you answered YES to any of the above	ense revoked, suspended or a license? ilege of taking an examing the before a State Medical dense or prescribe controphed in this state or any d, had your privileges repospital staff? The treatment of a mental for drug dependency or a lagainst you in a malpracty criminal offense other the equestions, please proving the state of	cancelled? intion before Board? illed sub- other? stricted or illness? lcoholism? tice suit? than minor 10. yES NO.
SIGNATURE OF APPLICANT: Ama Car	noll MP.	DATE: 6/25/88
in which the applicant has This certifies that Nina M. Carrol Senior Assistant Resident beginning July 1, 1985 Is the purpose of this application par If yes, is this program ACGME or RRC a so accredited (i.e. fellowship), does residency training program in the application par the application par the application par so accredited (i.e. fellowship), does	received an appointment. has bee in Boston City (Name and ending June ticipation in a training ccredited? Yes (yes your institution have an	n appointed to the position of Nospital Of Hospital) 30, 1986 program? Yes (yes or no or no) If the program is not ACGME or RRC accredited
Maxine Kesslex SIGNATURE	Director of Physicia OFFICIAL CAPACITY	

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

The commonwealth of massachusetts of ice the promote dates. BOARD OF REGISTRATION IN MEDICINE LAND PROMOTE DATES.

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW Fee of \$25.00 must accompany application-no currency or personal checks)

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECOMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECOMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD	FOR OFFICE USE Date Received Certificate #
ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.	By:Form of Fee:
SECTION 4: Sworn statement to be completed by applicant. Plea Name: Ninh MARK CAMOL Mailing Address: First Middle Last Date of Eirth:	
Pre-medical School: Costración Chinge Medical School: Lin Have you ever neld a previous LIMITED REGISTRATION IN MASSACHUS	ETTS? 24392
Have you ever neid a previous Limitel Redistration in Massachus	(give number, if applicable
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SECTION B: To be completed and signed by the Superintendent or in which the applicant has received an appointment.	Administrator of the Hospital
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in (Name	of Hospital)
beginning and ending	•
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SIGNATURE OFFICIAL CAPACITY	DATE
ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT	MADE UNDER PENALITIES

OF PERJURY.

To be completed only if you attended college outside of the United States, Canada or Puerto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION (to be completed ONLY by the Dean of the School)

Date May 5th

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To be completed only if you attended college outside of the United States, Canada or Puerto Rico.

VERIFICATION OF PRE-MEDICAL EDUCATION (to be completed ONLY by the Dean of the School)

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If candidate has attended more than one medical school, additional verification of medical instruction is required.



BOARD OF REGISTRATION IN MEDICINE

APPLICATION FOR LIMITED REGISTRATION AS INTERN, NEUICAL OFFICER OR FELLOW (Fee of \$25.00 must accompany application-no currency or personal checks)

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETIS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.	FOR OFFICE USE Date Received Certificate # By:Form of Fee:
SECTION A: Sworn statement to be completed by applicant. Pleas Name: NINA MARE CARROLL Mailing Address: First Middle Last Date of Birth:	-
Pre-medical School: Boston UNIVERSITY Medical School: From Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSE	173 of MED. Unichody Of Lieu 1757 84392— BELG. (give number, if applicable
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Make changes to name here				
Mass License # 57518 License Status Active			First Issue Date	04/22/87
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Fenway Cmnty.Hlth.Ctr. 7 Haviland Street Boston, MA 02115 U.S.A. (617) 277-3009	Bet	th Israel Hospital ount Auburn Hospital		
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Fi	nal Decisions and orders issued by the M	assachusetts Board of Registration	in Medicine.
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Ti	cluded when the court system is fully con	nputerized. Please list any crimina	the present time. This information will be I convictions. Include conviction date and nature
of	***************************************		
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Note: Please return the survey in the enclosed envelope to: Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103



THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — \$150.00 must accompany APPLICATION — No currency or personal checks)

Promotive: April 1974 April 1974 Address Date of Issue 42287 Press Print Name NINH APRIL CARRIOL Address Medical Education First Middle Place of Birth NEW GEDFORD MA Pre-Medical Education School New-Energy U. Bosen University Years Attended 1974 1974 April School University Fostgraduate Education & Hospital Appointments Position Dates Posityraduate Education & Hospital Appointments Position Dates Posityraduate Education & Hospital Appointments Position Dates Posityraduate Education NOSTETTICS 6/83 to present And GYNETOLOGY List all other states in which you have been fully licensed: NONE List Specialty Boards by which you are certified: NONE 1. Was any license ever revoked, suspended, or cancelled? 2. Have you ever been denied a license? 3. Have you ever been denied the privilege of taking an examination? 4. Have you ever been requested to appear before any State Basic Science or Medical Board? 5. Have you ever been requested to appear before any State Medical Board? 6. Have you ever been requested to appear before any State Medical Board? 7. Have you ever been requested to appear before any State Medical Board? 8. Have you ever been requested to appear before any State Medical Board? 9. Have you ever been requested to appear before any State Medical Board? 9. Have you ever been requested to appear before any State Medical Board? 9. Have you ever been requested to appear before any State Medical Board? 9. Have you ever been requested to appear before any State Medical Board? 9. Have you ever been requested to appear before any State Medical Board? 10. Have you ever been requested to appear before any State Medical Board? 11. Have you ever precited any other branch of the Healing Arts? 12. Have you ever precited any other branch of the Healing Arts? 13. Have you ever been warded, censured, or requested to withdraw from a hospital staffs. 14. Have you ever been asked to surrender your Narcotics Stamp? 15. Have you ever been asked to surrender your varcotics or have your varcoti	Filed:	For C	Office Use	Application # 60738
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Name NINA MARIE CARRELL Law Date of Birth NEW BEDFORD, MA Pre-Medical Education School Namewreen U. Boston University Years Attended 1974 1974-M76 Postgraduste Education & Hospital Appointments Postgraduste Education PACLITY of Medical Education	Please Print	VOTE 4/22/87 SWORN:	STATEMENT Date: 2	
Place of Birth NEW GEDFORD MA Pre-Medical Education School Newton Text U. Bosson University Years Attended 1974 /974- M76 Posigraduate Education & Hespital Appointments Position Dates School University of Education Posigraduate Education & Hespital Appointments Position Dates Position Dates ACTIVET OF ACTIVETY OF ACTIVETY OF ACTIVETY And GUNETOLICAY List all other states in which you have been fully licensed: NUNE Other names under which you have been licensed: NONE 1. Was any license ever revoked, suspended, or cancelled? 2. Have you ever been denied a license? 3. Have you ever been denied an examination before any State Basic Science or Medical Board? 4. Have you ever been requested to appear before any State Medical Board? 5. Have you ever been requested to appear before any Medical Society? 6. Have you ever been requested to appear before any Medical Society? 7. Have you ever been asked to surrender your Narcotics? 8. Have you ever been asked to surrender your Narcotics? 9. Have you ever been wirned, censured, or requested to withdraw from a hospital staffs 10. Have you ever been patient for the treatment of mental illness? 11. Have you ever been patient for the treatment of mental illness? 12. Have you ever been apatient for the treatment of mental illness? 13. Have you ever been arrested, or summoned into court as a defendant, or indicted or convicted, or fined, or imprisoned, or placed on probation, or has any case against you been filed, or have you ever forfeited collateral for breach or violation of any law or police regulation or ordinance whatsoever?	Name NINA			-
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BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee - \$150.00 must accompany	APPLICATION No	currency or personal checks)
(ree — 3150.00 must accompany		currency or personal enterior

Filed:	For Office Use Application # 66738
Form of Fee: M'onder	Certificate # Date of Issue
	DRN STATEMENT Date: 3/25/86
Name NINA MARIE CARROL First Middle Last	Address
Date of Birth	
Place of Birth NEW BEDFORD , mA.	
Pre-Medical Education	Medical Education FACHUTY OF MEDICINE
School Northeastern U. Boston U	School UNIVERSITY OF LIEGE
Years Attended 1974 1974-19	936 Years Attended 1977 - 1983
Postgraduate Ed	ucation & Hospital Appointments
BOSTON CITY HOSPITAL RESIDEN	TI IN OB GYN 6/83 to present
List all other states in which you have been fully license Other names under which you have been licensed: List Specialty Boards by which you are certified:	NONE
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THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — \$150.00 must accompany APPLICATION — No currency or personal checks)

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100000	Y HOSPITAL	Ano	1 GYNESO	coay	9/83	10 piceselo
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If you answered YES t	o any of the above que	estions, PLEA	SE GIVE DE	TAILS.		
						71-7-7-7-1

BOARD OF REGISTRATION IN MEDICINE SEE REVERSE SIDE SEE REVERSE SIDE YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.) IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: TEN WEST STREET BOSTON, MASSACHUSETTS 02111 RENEWAL APPLICATION 1987-1989 PLEASE USE THE ENCLOSED RETURN ENVELOPE LICENSE NUMBER **PAY THIS** DATE TO BE RENEWED LATE FEE THIS APPLICATION MUST BE SIGNED AMOUNT REGISTRATION NO AND RETURNED WITH A \$100 PAY-MENT. A CENTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CODE MO DA YR 89 9 \$100 CHECKS ARE ACCEPTABLE. PAYABLE TO: Carroll COMMONWEALTH OF **MASSACHUSETTS** TEN WEST STREET, 2nd FLOOR BOSTON, MASSACHUSETTS 02111 PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW YOU MUST READ THE-INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26. XiMil 2. Date of Birth: 1. Print Name: 3. Medical School: Un't of M.D.? D.O.? (Check One.) Delgium 5. Date of Graduation: 4. Country where Medical School located: American Specialty Board Certifled? (Check if yes.) Which Boards? . 7. Principal Specialty(ies): 8. Principal work setting: 9. Home address: __ 10. Principal business address: 11. List all hospitals at which you have currently effective privileges: . List all hospitals at which you have held privileges in the past 20 years; ... 13. States other than Massachusetts in which you are presently licensed to practice: ____ 14. List any other states where you were previously licensed to practice: __ YES NO 15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was tiled in relation to the claim)? 16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? 17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? 12. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time? 19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason? 20. Have you ever had any mental illness which has Impaired your ability to practice medicine or to function as a student of medicine? 21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? 23. Have you ever, for any reason, lost American Specialty Board Certification? 24. Have you been denied recentification by one or more specialty boards? If yes, which one(s)? 25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: 26. I am an active inactive practitioner. (Check One.) I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE. PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASON-ABLE CHARGE FOR MY SERVICES. PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NOTE: THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

(See Reverse Side)

DATE: __

SIGNATURE



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

Fee Renewal Date Board Use Only: Registration No. Status 03/09/<u>8</u> \$150 M.R. NINA M CARROLL D.E important: Read the accompanying instructions in their entirety before completing this torus. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action. . Print legibly or type your answers. . Answer all non-optional questions (front and back of form) completely-it is not adequate to state that the Board aiready has the information. . Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature. . Make a copy of this form and all attachments for your own records—you must give hospitals and other health care facilities copies for credentialing purposes. . Enclose the \$150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts. 1. a) Name (LAST:) CARROLL 1. b) Other Name(s), if any, that you were ever licensed under: 2. a) Address (Mailing):____ 2. b) Address (Home):____ 2. c) Address (Business): 114 NHIT WELL ST.

CHUMPY MA - 02:69

2. d) Telephone (Business): (6.17) 770 - 3023 Extension 2. e) Telephone (Home) (Optional) 4. Sex: MALE___FEMALE 5. Social Security No. (Optional): 3. Date of Birth (MO/DA/YR):__ 6. a) Medical School Code (See Table 1): BELD3 If 99999, write Name: 5. b) Year Graduated: 1983 6. c) Degree: M.D. \checkmark D.O. 6. d) Country: U.S. Canada Code if Other (See Table 2): 15 # 999, write Name: human harsed 7. Work Setting (Circle and indicate Percent(%) of Practice Time): 10 Hospital 100 % 15 Private Office 20 Partnership/Group Practice <u>____</u>% 30 Mental Health Center 46 Educational Institution 60 Plant/Commercial Setting 25 Clinic 35 Nursing Home % 40 HMO Facility 50 Medical Society 55 Government Facility 99 Other 8. Professional Activity (Circle and Indicate Percent(%) of Professional Time): 8. b) Mass. Lic. Issue Date % 20 Practice Involving Direct Patient Care
% 40 Medical Teaching 10 Resident or Fellow (see your wall certificate) 30 Administrative Activities _____% (MO/DA/YR): 4 /22/87 50 Medical Research 99 Other 9. Specialty Code (See Table 3): DBG Percent of Practice Time: 100 % Specialty Code: Percent of Practice Time: % If OS, specify: ___ 10. a) Are you American Specialty Board Certified? (Y/N) N 10. b) If YES, circle which Board(s): NM Board of Nuclear Medicine
OG Board of Obstetrics & Gynec ΑI Board of Plastic Surgery Board of Allergy & Immunology Board of Obstatrics & Gynecology Board of Anesthesiology Board of Preventive Medicine Board of Ophthalmology Board of Orthopedic Surgery Board of Psychiatry & Neurology CRS Board of Colon & Rectal Surgery OP Board of Dermatology Board of Radiology Ð os Board of Emergency Medicine FΜ Board of Otolaryngology OT Board of Surgery FP Board of Family Practice PA Board of Pathology Board of Thoracic Surgery PE IM Board of Internal Medicine Board of Pediatrics Board of Lirology Board of Neurological Surgery PMR Board of Physical Medicine & Rehabilitation 11. a) Hospitals at which you have <u>currently</u> effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. (See Table 4.) Facility Code: _____ Facility Code: 151 100 % Facility Code: _____ Facility Code: ff 999, write Name(s): 11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. (See Table 4.) Facility Code: 3 0 3 Facility Code: 0 8 4 Facility Code: 0 4 1 Facility Code: 0 2 0 Facility Code: If 999, write Name(s): I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts. Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services. Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. Note: This applies even if you reside out-of-state or out of the country. i hereby certify under the penalties of perjury that all information on this form—front and back and (#) attached pages—is true.

Signature: Mrs Carm

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

12. a) Other States where you previously were licensed to practice (Abbreviate): 13. I arn applying to be registered with the following status: ACTIVE INACTIVE #ACTIVE answer questions 14. a) through c). 14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: (Fill in # of hours or type of residency, or check waiter). Category: [JO2] hrs., Category: III. hrs., (Resk-Management: JO hrs.); Residency Program in: Waiver Requested (You must fill but a separate Waiver Form.) 14. b) My medical malpractice insurance is covered by INSURANCE CARRIER LETTER OF CREDIT ## applicable, check one and identify the name. Institution issuing Letter of Credit: Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how) 14. c) Percent of Practice Time in Massachusetts: JOD % Ouestions: 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to gach question. Provide details on Form 15A, attached. Yes No 15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? 16. Have you been a detendant in any pending or hea amy 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, international). If you answered 'YES' to question 15, 16, or 17 provide details on Form 15A, attached. Ouestions: 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to gach question. Provide details in the next section. Yes No Notice Time in Massachusetts in the next section of the past four years only. Check either YES or NO (not N/A) to gach question. Provide details in the next section. If you answered 'YES' to question 15, 16, or 17 provide	Fill in name and number. Physi	cian Last Name:	Microll		Registration No.	£.	<u> 518</u>
13. I am applying to be registered with the following status: ACTIVE INACTIVE # ACTIVE answer questions 14, a) through c). 14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: (Fill in # of hours or type of residency, or check waiver.) Category !: 10/3 hrs., Category !! hrs., (Fisk-Management: 10 hrs.); Residency Program in: Weiver Requested (You must fill out a separate Waiver Form.) 14. b) My medical malpractice insurance is covered by INSURANCE CARRIER LETTER OF CREDIT. If applicable, check one and identify the name. Institution issuing Letter of Credit: Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how) 14. c) Percent of Practice Time in Massachusetts: 100 % Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached. Yes No 15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? 16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?. 17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations—See Instructions) been taken against you by any governmental authority, hospital of other health care facility, or professional medical association (international. If you answered YES' to question 15, 16, or 17 provide details on Form 15A, attached. Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section. Yes No Has you been called before or been warried by this state or any other jurisdiction including a federal agency? 18. Has you privilege to possess, dispense or prescribe controlled substances been suspended, revoked	12. a) Other States where you are	now licensed to practice (Ab	breviate): 💆 🗍				
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Category I: 103 hrs., Category II: hrs., (Risk-Management: 10 hrs.); Residency Program In: Waiver Requested (You must fill out a separate Waiver Form.) 14. b) My medical malpractice insurance is covered by INSURANCE CARRIER LETTER OF CREDIT If applicable, check one and identify the name. Insurer: J. J. A. A. Institution issuing Letter of Credit: Insurer: J. J. A. A. Institution issuing Letter of Credit: Insurer: J. J. A. A. Institution issuing Letter of Credit: Insurer: J. J. A. A. Institution issuing Letter of Credit: Insurer: J. J. A. A. Institution issuing Letter of Credit: Insurer: J. J. A. A. Insurer: J. J. A. Insurer: J. J. A. Insurer: J. J. A. Insurer: J. J. J. J. A. Insurer: J. J. J. J. A. Insurer: J.	13. I am applying to be registered	d with the following status:	ACTIVE V	INACTIVE	HACTIVE, answer questions 14. a H INACTIVE, answer question 14.	i) throug b) only	gh c).
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24. Have you been denied recertification by one or more specialty boards? If YES, list Board(s):							
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30M - 9/90 - P813971

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

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• •			nduated: 53 Degree	. M.D. Scho	o! Code:	Y	ear Gradu	uated:	Dear	ee (MD/DO):
Name of Scho		, , , , , , , , , , , , , , , , , , , ,								
		ا معاف	Universite o	1						
a) Other States	where you are now	licensed to	practice (Abbr):	Je Cets	t d-6 +					
			practice (Abbr):			C	` \			
,			F (* 10-1)							
. Specialty Code	(s) (See Table 3):									
Code	Hours per Week i	n Mass.		-	Code		Hours	per Week in	Mass.	
203			ics and Gyne	a colony	DB	G		1-30		
3 24	û vo	316(1	ics and dyne	ecocopy						
				If OS	S, write spec	cialty:				
				Ĺ						
.a) Are you Amer	ican Specialty Boa	rd Certified	? (Y/N) N 7.b) If	YES, Enter Cod	les:	Ţ				
Code.	-		, 11			Code:				
Code						Code:				
. Drug License I	lumber(s) (il any) [optional]: a	Federal (DEA)		· · · · · · · · · · · · · · · · · · ·		b) How	many DEA	nos. do y	ou nave?
			State (MA) #M				·-	-	•	
. I have comple	ied my (; ki k men	riromente in	tha hua vaara araaadi	AM CONTRACTOR	into:	YES X			Address on the	equested

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

LIL	L IN NAME AND NUMBER: Physician Last Name: CARROLL Registration No. 57518
10.	
	List Insurer: TIA A 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: (State how otherwise exampl):
11.	Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).
	Facility Code: 151/MAP) Facility Code:/_(AP) Facility Code:/_(AP)
	Facility Code:/_(AP) Facility Code:/_(AP) Facility Code:/_(AP)
	# 999, write Name(s):
	Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. (See Table 5.) Facility Code: Facility Code: Facility Code:
	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? YesNo_X (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? 30 hrs./wk. in MA. b) How many hours per typical week are you currently involved in inpatient care in MA? 2 hrs./wk. in MA.
	Principal Work Setting. a) What is your principal work setting? (See Table 6) 3 0
Out	estions 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.
Rel	es to the instruction hooklet for additional information.
Re	er to the instruction booklet for additional information.
<u>Rel</u>	er to the instruction booklet for additional information. Yes No Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
15. 16. 17.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any 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)?
15. 16. 17.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any pending or new criminal 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 by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? 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?
15. 16. 17.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any pending or new criminal 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 by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? 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?
15. 16. 17.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or the criminal 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 by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? 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? Have you withdrawn an application for a medical license or been denied a medical license for any reason?
15. 16. 17. 18.	Has any pending or new medical malpractice claim been made against you (whether or not 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? 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)? 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? 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?
15. 16. 17. 18.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or the criminal 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 by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? 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? Have you withdrawn an application for a medical license or been denied a medical license for any reason?
15. 16. 17. 18. 19. 20. 21 22. Putas	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any 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)? 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? 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? Have you now, or have you been in the past four years, dependent upon alcohol or drugs? Are you now, or have you been in the past four years, dependent upon alcohol or drugs?
15. 16. 17. 18. 19. 20. 21 22. Put tax	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or the criminal proceeding other than a minor traffic offense?
15. 16. 17. 18. 19. 20. 21 22 Putate cool i co	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any 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)? 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? 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? Have you now, or have you been in the past four years, dependent upon alcohol or drugs? Are you now, or have you been in the past four years, dependent upon alcohol or drugs?
15. 16. 17. 18. 19. 20. 21 22 Putate cool i co	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any 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)?

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 27512 ACTIVE \$250.00 53/09/93 \$25.00	COLLECTION OF MARKING MAGNETS.
Mailing Address:	Address (Mailing): City/Town: State: Country Code (See Table 1):
 Directions: Staple check to bottom of form. Add late fee if necessary Questions 1-8 include information from Board files. Please correct as ne 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 each tendent of the second of th	are optional you will need copies ach copy it provides. order or personal check made Bk/D.E. 3/4/9 O. W.
Pre-Printed Information	Corrections of Pre-Printed Information
1. Other name(s), if any, under which you were licensed:	Name:Address (Home):
2. a) Address (Home):	City/Town: State: Country Code: Address (Business): WOMEN-CARE, D.C. 02174
b) Address (Business): 114 WHITWELL STREET SULNCY NA 02109	City/Town: 180 MASS, AVE. ARLINGTON MA Country Code: 0 If 999 print Country:
3. Date of Birth: Lic. Issue Date: 04/22/87 SS#: Telephone Number: Home () - Business (017)770-3033	Date of Birth (M/D/Y): / Sex (M/F): SS#: Telephone Number: Home: Business: (17) 648-4221 Full Name of Medical School:
4. Name of Medical School: Faculte de Medecine, Université de l'otat à Liege Year Graduated: 85 Degree: MD	Year Graduated: Degree (MD/DO):
5. a) Other states where you are now licensed to practice (Abbr): b) States where you previously were licensed to practice (Abbr):	Code Hours per Week in Mass.
6. Specialty Code(s) (See Table 2): Code Hours per Week in Mass. 33 30 Obstetrics and Gynecology	O B G 50 If OS, print specialty:
7. a) If you are currently American Specialty Board Certified, enter Codes Code: Code:	Code: OO Code.
 b) If you previously were American Specialty Board certified, but are n please enter codes of prior certification: (See Table 3) Code: Code; 	Code: Code:
8. Drug License Number(s), if any: a) Federal (DEA) b) State (MA)	Federal (DEA): State (MA):
9. I have completed my CME requirements in the two years preceding my You must fill out a separate Waiver Form. The waiver must be granted	y renewal date: Yes X No, waiver requested 1 by the Board before your license will be renewed. See instructions for

Staple Check Here

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

10. Activity Status: I am applying to be registered with the following status: Active X Inactive Inactive Inactive Inactive Inactive Inactive Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.
11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT If applicable, check one List Insurer:
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: 109/4/(AP) Facility Code: 11/4/(AP) Facility Code: 12/4/(AP) Facility Code: 12/4/(AP) Facility Code: 12/4/(AP) Facility Code: 12/4/(AP) Facility Code: 12/4/(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 C
If 999, write name(s):
13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? YesNo (Check one)
14. a) What is your principal work setting? (See Table 5) 1 5
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? ii) How many hours per typical week are you currently involved in inpatient care in MA? 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:
15. Her any medical explanation of him have made assigned your substance of a local control of the solution of
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?
16. Have you been charged with any criminal offense, other than a minor traffic violation?
 16. Have you been charged with any criminal offense, other than a minor traffic violation?
 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?
 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 controlled a medical license for any reason?
 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 controlled 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?
 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 controlled 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?
 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 controlled 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?
 16. Have you been charged with any criminal offense, other than a minor traffic violation?
16. Have you been charged with any criminal offense, other than a minor traffic violation?
 16. Have you been charged with any criminal offense, other than a minor traffic violation?

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 Fe 57518 ACTIVE \$250.00 03/09/95 \$25.0	
Mailing Address: NINA M CARROLL, M.D. 1224 BOYLSTON STREET CHESTNUT HILL, MA 02167	Address (Mailing): City/Town: State: Coumry:
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 ability to practice medicine in the Commonwealth. (See enclosed letters)	and may affect your
· Add late fee if necessary.	P. C. Lindowski and C.
 Make a copy of this form and all attachments for your own records credentialing and other purposes. The Board will charge a fee for each of See instructions on detachable coupon at bottom of this page. 	- you will need copies for
Pre-Printed Information	Corrections of Pre-Printed Information
1. Other name(s), if any, under which you were licensed:	
2 Home Address:	Name: Address: City/Town: State: Zip: Country:
3. Date of Birth: Sex: F Lic. Issue Date: 04/22/87 SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Lic. Issue Date (M/D/Y):/ SS#:
Home Phone Business Phone 617) 648-4221	Home: () Business: (6/17 277-3/19 Full Name of Medical School:
4. Name of Medical School: Faculte de Medecine, Universite de L'Etat a Liege Year Graduated: 83 Degree: MD	Year Graduated: Degree (MD/DO):
5. a) Other states where you are now licensed to practice (Abbr): 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. G Y N 50
OBG 50 Obstetrics and Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes:	i i
Code: OG Code:	Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts	Federal (DEA): Mass:
9. Activity Status: I am applying to be registered with the following sta	atus: ACTIVE X INACTIVE

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

PRINT NAME AND NUMBER: Physician Last Name: CARROL Registration Number:	5751	8
PRINT NAME AND NUMBER: Physician Last Name: CHRROLL Registration Number: 10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supplying the complete of the provision of patient care.		
codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).		
Facility Code: 4 / (AP) Facility Code:/ (AP) Facility Code:/		
Facility Code: 7 / (AP) Facility Code: /(AP) Facility Code: /	-(AP)	
If 999, print name(s):	the past 2 i	vears
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in		
(See Table 3) Facility Code: 4 / Facility Code: 6 0 Facility Code: 3 8 Facility Code: 1 0 8 F	de:	
If 999, write name(s):	·····	
11 My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, chec		
Alternatively, indicate as follows: 1 am registering with ACTIVE status, but I am not covered by medical malpractice insurance beca (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: (ii) Otherwise exempt: State how otherwise exempt:		
12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes No (Chec	ck one)	
13. a) What is your principal work setting? (See Table 4)		
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? hrs/wk		
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 details of the past two years only.	ails on	
Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.		
IN THE PAST TWO YEARS:	YES	NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
The any lawrent other than a medical malwactice suit, which is related to your competency to practice medicine, or your pro-		
fessional conduct in the practice of medicine, been filed against you by a patient, or been senied, adjudicated or based with		
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, defined		
20. Using you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your aminy to practice meanther:		
22. If you are consider 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 trial a medical		
25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested	will be	
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your hearts. So instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.		240
Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reason	ledge and	belief
 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 know. I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: The properties of the pains and paid all Massachusetts. 	his applies	i
• Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will ruini my obligation to report abuse of neglect of canal		-
G.L. c. 119, sec. 51A. I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.	e. -	
Signature: Date:	1195	
Signature:		



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 n 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.: 57518 Renewal Date: 03/09/97				
1. Activity Status: Active Retiring (see (Check only one) Inactive *(see below) Do not wish	to renew			
2. Other Name(s), if any, under which you were licensed:	Corrections (type or print) 3/3			
	Other Name(s):			
3. A ^{Mailing}	Mailing Address:			
NINA M CARROLL, M.D.	City/Town: State:			
1224 BOYLSTON ST CHESTNUT HILL, MA 02167-2104	Zip: Country: US			
B)Home Address:	Other Address:			
2)	City/Town:State:			
	Zip: country: US			
Home Phone: Business Phone: (617) 277-3119	Home: () Business: ()			
•	Date of Birth (M/D/Y):/_/ Sex (M/F):			
4. A) Date of Birth: C) Sex: F B) Lic. Issue Date: 04/22/87 D) SS#:	Lic. Issue Date (M/D/Y):/_/ SS#: Full Name of Medical School:			
5. A) Name of Medical School:				
Faculte de Medecine, Universite de				
1'Etat a Liege B) Year Graduated: 83 C) Degree: MD	Year Graduated: Degree (MD/DO):			
6. Specialty Code(s) (See Table 1)	Code(s) Hours Per Week in Mass.			
Code(s) Hours per Week in Mass.				
GYN 50 Gynecology	If OS, Print Specialty:			
7. Current American Board of Medical Specialties Certification	on (See Table 2) Code: Code:			
Code: OG Code:				
8. Drug License Numbers, if any:A) Federal (DEA):B) Massachusetts:	Federal (DEA): Mass:			
9. A) Other states where you are now licensed to practice Abbr:	Abbr:			
B) States where you previously were licensed to practice Abbr: CT	Abbr:			

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

PR	INT NAME AND NUMBER: Last Name:	CARROLL	Registration Number: 57518
	A. Current health care facilities at which you have Table 3 and place a check mark next to those he Facility Code: 69/(AP) Facility Code: 7/(AP) 1f 999, print name(s):	completed the credentialing process for the	e provision of patient care. Supply the codes fing privileges (AP). Facility Code: / (AP) Facility Code: // (AP)
	B. Additional health care facilities at which you (See Table 3)	previously held privileges or with which y	ou were associated in the past two (2) years.
	Facility Code: Facili		
11.	My medical malpractice insurance is covered by a) X Insurance Carrier b) Lett	er of Credit
	Name of Insurer: CRICO		
	Alternatively, indicate as follows: I am register		
	I am (check one) a) Not involved in d	direct/indirect patient care in Massachusetts	b) Otherwise exempt
12.	Are you currently in a post-graduate training progra	am in Mass, as a resident or clinical fellow	? (check one) Yes We No
13.	A. What is your principal work setting? (See Table	e 4) <u>1</u> <u>5</u>	
	B. Care of patients in Massachusetts (see instruction	on booklet).	
	1) Average weekly hours involved in:	a) outpatient care 20 hrs/wk	b) inpatient care H hrs/wk
	2) What is the approximate percentage of you	or patient care hours in primary care?	%
p/	ART A		
<u>deti</u>	stions 14 through 22 refer to the past two (2 ils on Form R for all YES answers except fonitions.		
	THE PAST TWO (2) YEARS:		YES NO
	CLAIMS MADE: Has any medical malpractice cleadjudicated, whether or not a lawsuit was filed in re	elation to the claim?	
	CLAIMS RESOLVED: Has any medical malpra otherwise resolved, whether or not a lawsuit was file	ed in relation to the claim?	
16.	Has any lawsuit, other than a medical malpractice st professional conduct in the practice of medicine, because		
	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		
19.	Has your privilege to possess, dispense or prescribe denied or restricted by any state or federal agency?	controlled substances been surrendered to	or suspended, revoked,
2 0.	Have you withdrawn an application for a medical lic	cense or been denied a medical license for a	iny reason?
21.	Has any professional liability insurance provider res placed any condition related to professional compete limited or terminated your insurance coverage in res	ency or conduct on your coverage or have y	you voluntarily restricted,
22.	Have you completed your CME requirements preced	ding your renewal date (see instruction boo	klet)?
	Waiver requested (waiver form due 30 days price	or to date of license expiration). Training	g Program exemption
See	Instructions for CME requirements. Do not su	bmit documentation of your CMEs wit	h your renewal application.
	RENEWAL APPLICATION CONTINUED		N <u>PART B</u> MUST BE ANSWERED.
Sìgn	ature Arra Can	M W	Date: 2-/22-/97
	/ * * * * * * * * * * * * * * * * * * *		

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Page: 1

Massachusetts Board of Registration in Medicine Physician Profile

NINA M. CARROLL, MD

This Profile is not available for public release until 11 April 97

Physician Information

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

Dr. CARROLL has been fully licensed in Massachusetts: 10 years

Accepting new patients? Yes

Accepts Medicaid? Yes

BOYLSTON

Primary work setting: Private Office

Business address: B.I. HEALTHCARE\ STR 311
25 DOVLECTON STREET

CHESTNUT HILL, MA 02167-Phone: 617-277-3119

Translation services available: None

Insurance Plans Accepted

Hospital Affiliations

Beth Israel Hospital Mount Auburn Hospital

HMO Blue BCBS (Indemnity) Tufts PILGRIM ARTNA US HEALTHCARE STATE HANCOCK

CIGNA PRUCARE OTHER PLANS

II. Education & Training

Faculte de Medecine, Universite de l'Etat a Liege Medical School:

Graduation Date: 1983

INTERNSHIP: OB/GYN RESIDENCY: OB/GYN

Post Graduate Training: 07/01/83 - 06/30/84 BOSTON UNIV MED CTR 07/01/84 - 06/18/87 BOSTON UNIV MED CTR

III. Specialty

Gynecology ABMS Board Certified: Obstetrics & Gynecology

IV. Honors and Awards

This physician has reported no awards.

V. Professional Publications

GYNECOLOGICAL INFECTIONS AND SEXUAL PRACTICES.

(IN PRESS)

Massachusetts Board of Registration in Medicine Physician Profile

NINA M. CARROLL, MD

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 the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make 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

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 occurred.

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.

Dr. CARROLL has not made a payment on a malpractice claim in Massachusetts in the last ten years.

VII. Disciplinary Actions

Criminal Convictions

The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. CARROLL has had no criminal convictions in the past ten years.

Hospital Discipline

This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. CARROLL has no record of hospital discipline in the past ten years.

Massachusetts Board of Registration in Medicine Physician Profile

Page: 3

NINA M. CARROLL, MD

C. Board Discipline

This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. CARROLL has not been disciplined by the Board in the past ten years.



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. · Return renewal application in GREEN envelope, Remit \$250.00 for renewal fee. · Enclose check with coupon in BLUE envelope · Add late fee of \$25.00, if necessary. Renewal Date: 03/09/1999 1. Current Status: Active Registration No.: 57518 If you want to change your current status, please indicate below: (Check one). ☐ Inactive (see below *) Retiring (see instructions) Active Please make corrections (type or print) 2. Other Name(s), if any, under which you were licensed: Other Name(s): 3.A) Mailing Mailing Address: NINA M CARROLL, M.D. State: City/Town: B.I. HEALTHCARE\ STE 311 Zip: ____ Country: 25 BOYLESTON STREET CHESTNUT HILL, MA 02167 Other Address: B) Home Address: City/Town: _____ Zip: ____Country: ____ Home: (____)_ Home Phone: Business: () Business Phone: (617) 277-3119 Date of Birth: (M/D/Y): __/_/ Sex : __ M __ F Sex: F 4. A) Date of Birth: B) SS#: Full Name of Medical School: 5. A) Name of Medical School: Faculte de Medecine, Universite de l'Etat a Liege Degree: M.D. D.O. Year Graduated: B) Year Graduated: 1983 C) Degree: MD Hours Per Week in Massachusetts Code(s) 6. Specialty Code(s) (See Table 1) Hours per Week in Mass. Code(s) Gynecology GYN If OS. Print Specialty: 7. Current American Board of Medical Specialties Certification (See Table 2) Code: Code: Code: OG 8. Drug License Numbers, if any: Federal (DEA): A) Federal (DEA): B) Massachusetts: 9. A) Other states where you are now licensed to practice

Abbr:

B) States where you previously were licensed to practice

Abbr:

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

PRINT NAME AND NUMBER: Last Name: CARRELLE	Registration Number:	41512
10. Current health care facilities at which you have completed the credentialing proce the codes from Table 3 and place a check mark next to those health care facilities whe each facility, write the approximate percentage of patient care hours that you provide	ess for the provision of patient re you have admitting privile in each facility	t care. Supply ges (AP). Next to
Facility Code: 4 4 // (AP) 100 % Facility Code:/ (AP)	% Facility Code:/	(AP)%
Facility Code:/ (AP) % Facility Code:/ (AP) 9	% Facility Code: /	(AP)%
If 999, print name(s): 11. My medical malpractice insurance is covered by a) Insurance Carrier b)		
Name of Insurer: CRICO Alto	ernatively, indicate as follows	::
I am registering with Active status but I am not covered by medical malpractice insuran		
a) Not involved in direct/indirect patient care in Massachusetts b) Otherwi	•	
Please explain exemption:		
12. Are you currently in a post-graduate training program in Massachusetts as a residen	t or clinical fellow? (check or	ne) 🔲 Yes 📵 No
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 25 hrs/wk		∕wk
What is the approximate percentage of your patient care hours in primary care		
PART A - OUESTIONS REFER ONLY TO THE PAST TWO (2) Y	<u>EARS</u>	
Questions 14 through 22 refer to the past two (2) years only. Check either YES or details on Form R for all YES answers except for question 22. Refer to the instruct definitions. You must answer ALL questions, or this form will be returned to you a	ion booklet for additional is	formation and
		YES NO
14. <u>CLAIMS MADE</u> : Has any medical malpractice claim been made against you that settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	has not yet been finally	
15. CLAIMS RESOLVED: Has any medical malpractice claim that has been made a adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to t	gainst you been settled, he claim?	1
16. Has any lawsuit, other than a medical malpractice suit, which is related to your compor your professional conduct in the practice of medicine, been filed against you or be otherwise resolved?	petency to practice medicine, een settled, adjudicated or	
17. Have you been charged with any criminal offense, other than a minor traffic violatio	n?	
18. Have you been formally charged with or disciplined for any violation of laws, rules, practice of any governmental authority, health care facility, group practice or profess	by-laws or standards of sional society or association?]
19. Has your privilege to possess, dispense or prescribe controlled substances been surre revoked, denied or restricted by any state or federal agency?	ndered to or suspended,	
20. Have you withdrawn an application for a medical license or been denied a medical li	cense for any reason?	1
21. Has any professional liability insurance provider restricted, limited, terminated, important co-payment, or placed any condition related to professional competency or conduct of you voluntarily restricted, limited or terminated your insurance coverage in response professional liability insurance provider?	on your coverage or have	
22. CME CERTIFICATION: Have you completed your CME requirements preceding	your renewal date? V	s 🗍 No
CME Waiver requested (CME waiver form due 30 days prior to date of license		
See Instructions for CME requirements. Do not submit documentation of your CM		
 Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary m 	•	
 Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all M. Massachusetts state taxes that are required under law. <u>NOTE</u>: This applies even if you 	assachusetts state tax returns a reside out-of-state or out of the	and paid all United States.
 Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of chil 	dren as required by G.L. c. 11	9, § 51A.
 I hereby certify under the penalties of perjury that all the information on the Renew 	- ·	Ÿ
Signature: Mra Caum	Date: 2	14,99

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

Physician Registration Renewal Application

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

 Remit \$250.00 for renewal f Add late fee of \$25.00, if nec 		 Return renewal application in GREEN envelope. Enclose check with coupon in BLUE envelope. 		
alterations as required	llowing information for 57518	accuracy and completeness. Make any corrections or 03/09/2001		
Active 1. Current Status:	Registration No.:	Renewal Date:		
If you want to change your current sta	nus, please check one of the t	following boxes to indicate your <u>new</u> status: (Check only one)		
Active Retiring (see in		tive (see instructions) Do not wish to renew		
2. Other Name(s), if any, under which		Please make corrections (type or print)		
A) Mailing/Business Address:		Other Name(s):		
3 NINA M CARROLL 1400 Centre St Suite 206 Newton Centre, MA 02459 B) Home Address:	FEB 2 6 2001	Mailing Address: City/Town: State: Zip: Country: Business Address: City/Town: State: Zip: Country: Business Telephone: (617) 630-9800 Home Address: City/Town: State: Zip: City/Town: State: Zip: Country:		
Home Phone:		Home Telephone: ()		
Business Phone:	•	PLEASE NOTE: No P.O. Box addresses for home or business addresses.		
4. a) Date of Birth: b	F 7. C	Offent American Board of Medical Specialties Certification (See Table 2 Code: Code;		
c) SS#:	8.1	Drug License Numbers at any		
5. a) Name of Medical School: Faculte de Medecine, Universite 1983	a) Federal (DEA):) Massachusetts:		
	Degree: 9, a	Other states where you are now licensed to practice (Abbr.)		
6. Specialty Code(s) (See Table 1) Code(s) 0 Hours pre Week in M	ass. b	States where you were previously licensed (Abbr.)		
In Correct health care facilities at which	h you have completed the cre	elentialing 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).

P	RINT YOUR LAST NAME: CARROLL LICENSE NUMBER: 57	1518	•
1 1	. My medical malpractice insurance is covered by a) 🔀 Insurance Carrier b) 🔲 Letter of Credit		
11	Name of Insurer: Controlled Risk Distreme Co, of VT. Alternatively, indicate as follows:		
1.			
	arm registering with Active status but I am not covered by medical malpractice insurance because I am (check one)		
,	Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt		
	ease explain exemption:		65-Y
	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check o	ne) [Yes	N K
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 10 hrs/wk b) inpatient care	s/wk	
	2) What is the approximate percentage of your patient care hours in primary care? / D %		
PA	ART A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
			• . • .
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each qui ails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in Initions. You must answer ALL questions, or this form will be returned to you and your license renewal m	<u>nformatio</u>	n and
		YES	NO
14.	<u>CLAIMS MADE</u> : Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15.	<u>CLAIMS RESOLVED:</u> Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16.	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?	1	1
17.	Have you been charged with any criminal offense, other than a minor traffic violation?		l
18.	Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20.	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		İ
	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22.	CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? 🛛 Y	es 🔲	No
	CME Waiver requested (CME waiver form due 30 days prior to date of license expiration)	ME exemp	tion
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal appli-	cation.	
Pur	suant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule	e amount.	
Puri Mas	suant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and pachusetts state tax returns and pachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you reside out-of-state or out of the Uni	paid all ited States.	
•	Pursuant to G.L. c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119/withholding and remitting Child Support.	1 relating t	o
•	Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, §	SIA.	
	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R		
Sign	ature: Mira Canoll Date: 2	. , 14 ,0)

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

NINA CARROLL

PHYSICIAN PROFILE

(Information current as of 8/21/96)

Nina

M

Curroll

I. PHYSICIAN INFORMATION

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

Place Add:

Fenway Cmnty.Hith.Ctr. 7 Haviland Street Boston, MA 02115 U.S.A.

U.S.A. (617) 287-0900 BETH ISKAEL

OBJGYN FOUNDATION Affiliations
25 BOYL STON STREET Hmo Blue
CHESTNAT HILL, MA

Bebs (Indemnity)

02167

Tuffs Other Plans

Hospital Affiliations

Beth Israel Hospital Mount Auburn Hospital

Accepting New Patients? Accept-Medicaid?

IL FOUCATION AND TRAINING

Medical School:

Faculte De Medecine, Université De L'Etat A Liege 83

Post-Graduate Training:

IIL SPECIALTY

BOARD CERTIFICATION

Gynecology

Board Of Obsteirics And Gynecolog.

IV. HONORS AND AWARDS

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



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

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Physician Registration Renewal Application

a del lata foa o	resean if n	fee (non-refunda ecessary,	1	Enclose check	al application in GREEN envelope. with coupon in BLUE envelope.	
Please review car alterations as req	refully the juired. <u>All</u>	<u>questions</u> must	be answere	d or your renewal		'r
i. Current Status.	Active		on No.:57518		newal Date: 03/09/2003	
If you want to change	your current	status, please check			ate your new status: (Check only one)	
Active	Retiring (se	e instructions)	Inacti	ve (see instructions)	Do not wish to renew	
2. Other Name(s), if a	ny under wh	ich von were licens	ed:	Please make correc	tions (print)	
A) Mailing/Busine	ess Address:	ich you were needs	30 30.	Other Name(s)	Name Change (enter name below)	
3. NINA M CARI 1400 Centre St Suite 206				Mailing Address:City/Town:	State:	-
Newton Centre	, MA 02459			Zip:	Country:	-
B) Home Address	:			A 13	55 POND Avenue	-
			2.55	City/Town: BRC	Country: USA	- - -
					(617) 232-0202	_
					State:	
Home Phone:				Zip:	Country:	_
Business Phone:	617 6	30-9800		Home Telephone	Only one address can be a P.O. box. The	1
a) Date of Birth:	<u> </u>	o) Sex:			edical Specialties Certification (See Table	<u>2</u>)
c) SS#:		· ·	Code:	ense Numbers, if any:		
a) Name of Medical So	chool:		a) Fed	eral (DEA):		
Faculte de Medec b) Year Graduated:	ine, Universi c) De g	te de l'Etat a Liege ge: M.D.	•	ssachusetts: her states where you a	re now licensed to practice (Abbr.)	
pecialty Code(s) (See]	<u>(able 1)</u> r Week in M	ass.	•		eviously licensed (Abbr.)	
GYN 0	Gynecology			- — ст		
and the sade	ac from Table	. 3 and nisce a chec	k mark next to	o those nealth care laci	edentialing process for the provision process for the process for	itiei i (A

PRINT YOUR LAST NAME: <u>CARROL</u>	<u> </u>	LICENSE NUMBER:	57518
11. My medical malpractice insurance is covered by	Insurance Carrier	Letter of Credit	
Insurer's name. (Required): CRICO			3 To: 12 / 31 / 03
Alternatively, indicate as follows: I am registering because I am: Check One: Not involved in	g with Active status but I	am not covered by medical n	nalpractice insurance
Otherwise exempt Please explain exemption:			
12. What is your principal work setting? (See <u>Table 4</u> for the provision of patient care you must comple		re affiliated with a healthcare and list your affiliations.	facility or credentiale
13. Care of patients in Massachusetts (see instruction			
1) Average weekly hours involved in: A) in	atient care <u></u> hrs/wk	B) outpatient care 50) _hrs/wk
2) What is the approximate percentage of you	r patient care hours in prin	nary care? <u>0</u> %	
PART A - QUESTIONS REFER ONLY I	O THE PAST TWO	(2) YEARS (SEE INS	TRUCTIONS)
Ouestions 14 through 22 refer to the period since y	ou signed your last renew	al application. Check eithe	r YES or NO to each
question. Provide details on Form R for all YES at and definitions. ALL questions in this section mus	swers (except question 2	2). Refer to instructions for swar NA or the form will be	<u>r additional informa</u> e incomplete and del
your renewal.	NA BUSINESSE TO HOLAN	WHEN AND ME THE THE WHILD	e incombiete sua del
			YES N
14. CLAIMS MADE (New or Pending): Has any n	edical malpractice claim b	ocen made against you that ha	1
yet been finally settled or adjudicated, whether or 15. CLAIMS (Resolved): Has any medical malpra	not a lawsuit was filed in r	relation to the claim?	
adjudicated, or otherwise resolved, whether or no			İ
16. Has any lawsuit, other than a medical malpractice	suit, which is related to yo	our competency to practice m	edicine,
or your professional conduct in the practice of me otherwise resolved?	licine, been filed against y	ou or been settled, adjudicate	d or
17. Have you been charged with any criminal offense	•		ļ
18. Have you been charged with or disciplined for any any governmental authority, health care facility, g	violation of laws, rules, b	y-laws or standards of practi- al society or association?	ce of
 Has your privilege to possess, dispense or prescrit restricted by, or surrendered to any state or federal 	e controlled substances be	•	∍d,
20. Have you withdrawn an application for a medical	• •	edical license for any reason'	?
21. Has any professional liability insurance provider r	stricted, limited, terminate	ed, imposed a surcharge or	
co-payment, or placed any condition related to pro you voluntarily restricted, limited or terminated yo professional liability insurance provider?	fessional competency or co	onduct on your coverage, or l	ave
22. CME CERTIFICATION: Have you completed	our CME requirements pr	receding your renewal date?	Yes No
CME Waiver. CME waiver form must be sub	•	* •	-
CME EXEMPTION: Check one:		/Fellowship training (See in	•
See Instructions for CME waiver or exemptions		•	
 Pursuant to G.L. c. 112, Sec 1A, I understand and the punishment for failure to comply. 		_	•
 Pursuant to G.L. c. 112, Sec. 2, I will not char amount. 			
 Pursuant to G.L. c. 62C, 49A, I certify that I h Massachusetts state tax returns and payment o G.L. c. 62E; and withholding and remitting ch 	all Massachusetts state ta:	xes; reporting of employees a	and contractors a der
I hereby certify under the penalties of perjury that	all information on this R	Renewal Application, Part E	and Form R s true
Signature: Mira Cansh		Da	te: 2 / 10 / 03
YOU MUST SIGN AND INCLUD	PART B, WITH YO		
Board Regulations require that yo	s notify the Board. in	writing, of any change	of address

a mid,

Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL License No.: 57518

PART A	
1) Current Status: Active Renewal Due Da	
If you want to change your current status, please check (Check only one). (See Renewal Instructions, page 3	k <u>one</u> of the following boxes to indicate your <u>new</u> status:
	Inactive
2) Addresses & Contact Information. Please confirm your a required to notify the Board of Registration in Medicine wi Business addresses CANNOT of Past Office Box: 2a) MAILING ADDRESS OF STATE OF STAT	ithin 30 days of any change of address. Home and
S5 pond Ave. Brookline, MA 02445 Board of Medicine Check here to change this addition. In Medicine	Mailing Address: City/Town: State: Zip: Country:
2b) HOME ADDRESS	
abj itoma ito attack	Home Address:
	City/Town: State:
	Zip: Country:
Phone:	Home Telephone:
Check here to change this address	Home address cannot be a Post Office Box
2c) BUSINESS ADDRESS	Business Address:
55 pond Ave.	City/Town: State:
Brookline, MA 02445	Zip: Country:
	Business Telephone: ()
Phone: (617)232-0202	Business address cannot be a Post Office Box
Check here to change this address	Dustriess address edition be a 1 ost of the
3) E-mail Address:	
4) Fax Number: 617 739 - 720	3
5) Specialties (See Renewal Instructions, page 4.) Delet	te? Additional specialties:
Gynecology	
	1
(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?
X 0	Obstetrics & Gynecology
	0 0

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Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL License No.: 57518 (See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers, if any: 8a) Other states where you are now licensed to practice (Abbr.) a) Massachusetts: b) Federal (DEA): 8b) States where you were previously licensed (Abbr.) c) Federal (DEA) XS: 9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Private Office Hours per Week: 32 Change to: 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 Staff Category # Honrs Health Care Facility (See Renewal Instructions, page 4.) Delete? Current Change per Week Beth Israel Deaconess Medical Center Active Brigham & Women's Hospital Mount Auburn Hospital COURTESY women's HEALTH SERVICES 6-8 CONSULTING 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 21_ hrs/wk Change to: ___ hrs/wk Average weekly hours involved in: a) inpatient care Change to: 48 hrs/wk 50 hrs/wk b) outpatient care 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: From / / / 2005 To 12/31 / 2005 Policy dates: (required) Letter of Credit subject to Board approval (attach a copy) Lam 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: NINA M CARROLL License No.: 57518

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

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	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim?		
b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		•
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.		
a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?		
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES		
a) Have you been charged with any criminal offense during this time period?		
b) Are there any criminal charges pending against you today?		
c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		
22) CME CERTIFICATION:		
a) Have you completed your CME requirements preceding your renewal date? XYes 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.)	0	
c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page &	3.)	
CME EXEMPTION: (check one)		

Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL License No.: 57518

PHYSICL	AN I	PROF	ILE

	I have reviewed my Physician Profile at <u>profiles.massmedboard.org</u> and confirm that the information is accurate.
M	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: Mara Canoll Date: 1,28,05

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

Page 5 of 5

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Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. PART A Birth Date: Renewal Due Date: 02/09/2007 1) Current Status: Active If you want to change your current status, please check <u>one</u> of the following boxes to indicate your <u>new</u> status: Check only one: (See Renewal Instructions, page 3.) Do not wish to renew ☐ Retiring ☐ Inactive 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 Mailing Address: 55 Pond Ave. BECEIVEL City/Town: State: Brookline, MA 02445 JAN 1 1 200? Zip: Country: Check here to change this address 802rd of Hagistradon 2b) HOME ADDRESS Home Address: City/Town: State: Zip: Country: Home Telephone: (____)____ Phone: Home address cannot be a Post Office Box ☐ Check here to change this address 2c) BUSINESS ADDRESS Business Address: 55 pond Ave. City/Town: State: ____ Brookline, MA 02445 Zip: Country: Business Telephone: (____)____ Phone: (617)232-0202 Business address cannot be a Post Office Box ☐ Check here to change this address Correct your E-mail and Fax Number below: 3) E-mail Address: 4) Fax Number: 617-739-7203 5) Specialties (See Renewal Instructions, page 4.) Delete? List Additional Specialties: Gynecology 6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. (See enclosed instructions and Renewal Instructions, page 4.) Update General Certificates and Subspecialty Certificates List Certifying Board(s) below: below. Please add additional Certifications as required. Delete? Certificate/Subspecialty ABMS or AOA Board Name

Obstetrics and Gynecology

ABMS

Obstetrics & Gynecology

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Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518

7) Drug License Numbers Corrections:			
a) Magazaharatta	8) Other states where you	8) Other states where you are <u>now</u> licensed to practic	
a) Massachusetts: b) Federal (DEA):	9) States where you were	nreviously license	
c) Federal (DEA) XS:	CT CT	previousty needs	•
C) 1 000 (1 (D) 1) 715.			
10) List all work sites in Massachusetts, includ offices, clinics, nursing homes, etc. For the nan page 18 of the Renewal Instruction booklet. In or companies. Please provide all information o	nes of the health care facilities, refe iclude any affiliations with Internet	r to Reference T -based prescribi	able 4 on ng service
List the names of all work sites in Massachusetts (<u>See</u> above and description on page 4.)	Location (City or Town)	State	Delete?
Beth Israel Deaconess Medical Center	BOSTO N	MA	
Brigham & Women's Hospital	BOSTON	MA	
Mount Auburn Hospital	Cambridge	MA	
Other			
Women'S HEALTH SERVICES	CHESTNUT HILL	MA	
FOUR WOMEN	ATTLEBORO	NA	
Average weekly hours involved in: a) inpatient care b) outpatient care	re 40 hrs/wk Change to:		
12) Medical Liability Insurance Information (See Re	enewal Instructions, page 5.)		
12) Medical Liability Insurance Information (See Re Check one. Locum tenens must list policy dates. M		hrough:	
		hrough:	
Check one. Locum tenens must list policy dates. M			
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below)	(y medical liability insurance is provided to:		
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO	(y medical liability insurance is provided to: Change to: 12/31/2007		
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co	(y medical liability insurance is provided to: Change to: 12/31/2007		
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet)		
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet)	**************************************	am:
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert Letter of Credit subject to Board approval (A) I am registering with Active status but I am received to the complete of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet) Interpretation or indirect patient care in Massachusetts	**************************************	am:
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert Letter of Credit subject to Board approval (A) I am registering with Active status but I am received to the complete of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet) Itach a copy.) not required to have medical liability in or indirect patient care in Massachusetts and under Federal Tort Claims Act (FTCA)	**************************************	am:
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert Letter of Credit subject to Board approval (A) I am registering with Active status but I am received to the complete of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet) Itach a copy.) not required to have medical liability in or indirect patient care in Massachusetts and under Federal Tort Claims Act (FTCA)	**************************************	am:
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert Letter of Credit subject to Board approval (A) I am registering with Active status but I am received to the complete of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet) Itach a copy.) not required to have medical liability in or indirect patient care in Massachusetts and under Federal Tort Claims Act (FTCA)	**************************************	am:
Check one. Locum tenens must list policy dates. M Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From ////2007 To Type of Policy: Claims made with tail co (Enclose a copy of the cert Letter of Credit subject to Board approval (A) I am registering with Active status but I am received to the complete of the cert	Change to: 12/31/2007 Occurrence Policy ificate of insurance or the face sheet) Ittach a copy.) not required to have medical liability in or indirect patient care in Massachusetts e under Federal Tort Claims Act (FTCA) the explain):	surance because I	am:

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Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D.

License No.: 57518

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

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

YES NO

14) CLAIMS MADE a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or	
has any medical malpractice claim been made against you during this time period? (see above).	
b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have	
not been finally settled or finally adjudicated?	
15) CLAIMS CLOSED	
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?	
16) OTHER CIVIL LAWSUITS	
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.	
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?	
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?	
17) CRIMINAL CHARGES	
a) Have you been charged with any criminal offense during this time period?	
b) Have any criminal offenses/charges against you been resolved during this time period?	1
c) Are there any criminal charges pending against you today?	
d) Are any Applications for Issuance of Process pending against you?	
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS	
a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?	
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?	
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?	
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?	
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?	
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?	
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or	
co-payment, or placed any condition related to professional competency or conduct on your coverage, or	
have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by	
a medical liability insurance carrier?	
22) CME CERTIFICATION:	
a) Have you completed your CME requirements preceding your renewal date? Yes No	
b) If no, are you requesting a CME waiver?	
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)	

Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518

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	1.1	T.A.	

Check One:

PHYSICIAN PROFILE

X	I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate.
•	(Please note that if you changed or corrected your business address, business phone number, practice specialty, board
	certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
ا وسم	I have reviewed my Dhysician Profile and attached a conv of the Profile with corrections

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:

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

Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518

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, 200
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 w site at www.NPPES.cms.hhs.gov.
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org .
Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf. Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.
Check the appropriate box below, supply appropriate information, and sign the bottom of the page. My current NPI is:
☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.) ☐ I have applied for an NPI using a third party (enter name): (follow instructions for Option 3)
By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

HIPAA TAXONOMY CODES

Female

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

☐ Male

Gender:

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider

taxonomy code is required if you a	infunctive polytiki to apply for all Met off Anni occ	lali.
	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207VG0400X	OBSTENIES + GYNECOLOGY -
Provider Taxonomy:		CTYNECO
Provider Taxonomy:		
	NPI REQUIRED INFORMATION	
	e quality of the information we collect, please reviormation is required if you authorize BORIM to a	ew the following information and make correction apply for an NPI on your behalf.
Social Security Number:		
State of Birth (if US):	MASS. Country of Birth (if out	side the US):

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination			
I authorize the Box	ard of Registration in Medicine to provide m	y NPI to any authorized hospital,	health plan, or health organization.
Signature:	ard of Registration in Medicine to provide m	Date:	119107

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 OTHER PURPOSES.

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License No.: 57518 (Baun)

Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. PART A 1) Current Status: Active Renewal Due Date: 02/09/2009 Birth Date: If you want to change your current status, please check <u>one</u> of the following boxes to indicate your <u>new</u> status: Check only one: (See Renewal Instructions, page 3.) ☐ 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 55 Pond Ave. Mailing Address: Brookline, MA 02445 City/Town: _____ State: ____ Zip: Country: □ Check here to change this addr Board of Registration in Medicine 2b) HOME ADDRESS Home Address: City/Town: State: Zip: Country: Home Telephone: (____)__ Phone: Home address cannot be a Post Office Box Check here to change this address 2c) BUSINESS ADDRESS Business Address: 55 pond Ave. Brookline, MA 02445 Zip: Country: Business Telephone: (____) Phone: (617)232-0202 Business address cannot be a Post Office Box ☐ Check here to change this address Correct your E-mail and Fax Number below: 3) E-mail Address: 617-739-7203 4) Fax Number: 5) Specialties (See Renewal Instructions, page 4.) Delete? List Additional Specialties: Gynecology 6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. (See enclosed instructions and Renewal Instructions, page 4.) **Update General Certificates and Subspecialty Certificates** List Certifying Board(s) below: below. Please add additional Certifications as required. Certificate/Subspecialty Board Name ABMS or AOA Delete? **ABMS** Obstetrics and Gynecology Obstetrics & Gynecology

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Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518 (See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers Corrections: 8) Other states where you are now licensed to practice a) Massachusetts: b) Federal (DEA): 9) States where you were previously licensed c) Federal (DEA) XS: 10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary. List the names of all work sites in Massachusetts Location State Delete? (See above and description on page 4.) (City or Town) Beth Israel Deaconess Medical Center П Brigham & Women's Hospital × Mount Auburn Hospital Women's Health Services MΑ П CHESTANT HILL 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Average weekly hours involved in: a) inpatient care Change to: _____ hrs/wk 40 hrs/wk b) outpatient care Change to: 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 Policy dates: From 1/1/2009 To 12/31/2009 Claims made with tail coverage Type of Policy: 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.) No If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518

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

	1	
14) CLAIMS MADE		
a) NEW: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period? (see above).		
b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?	 	
15) CLAIMS CLOSED	<u> </u>	·
Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS		
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.		
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?		
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES		
a) Have you been charged with any criminal offense during this time period?	:	
b) Have any criminal offenses/charges against you been resolved during this time period?		
c) Are there any criminal charges pending against you today?		
d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS		
a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?		
b) Have you ever taken a leave of absence from any health care facility, group practice or employer?		
c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?		
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or		
have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		
22) CME CERTIFICATION:		
a) Have you completed your CME requirements preceding your renewal date?		
b) If no, are you requesting a CME waiver?	,	
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)		

Massachusetts Physician Renewal Application

Physician Name: Nina M Carroll, M.D. License No.: 57518

PART C

Check	COne: 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: Mi Canok Date: 2, 2,09

MAKE A LOPY 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.

Page 5 of 7

18,586867**2**80

87



Physician Name: Nina M Carroll, M.D. License No.: 57518

Current Status: Active License Expiration Date: 3/9/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 55 Pond Ave.

Brookline

Massachusetts - 02445 United States of America

Home Address:

Business Address: 55 Pond Ave.

Brookline

Massachusetts - 02445 United States of America

(617) 232-0202

3) Email Address:

4) Fax Number: (617) 739-7203

5) Specialties Gynecology

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

Information

ABMS/AOA Board Name Certification Subspecialty

ABMS Obstetrics & Gynecology Obstetrics and Gynecology

7) Drug License Numbers

Massachusetts Federal (DEA) XS

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

9) States where you were previously licensed Connecticut

10) Work Sites

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

WorkSite Location

Beth Israel Deaconess Medical Center

Brigham & Women's Hospital

Page 1 of 7 Date: 2/2/2011 Time; 6:48 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Other

Women's Health Services, PC.

Brookline, MA

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wkb) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Policy Start Date

Policy End Date

Policy Type

Risk Management Foundation

01/01/2011

12/31/2011

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?

Page 2 of 7 Date: 2/2/2011 Time: 6:48 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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

Page 3 of 7 Date: 2/2/2011 Time: 6:48 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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?

Page 4 of 7 Date: 2/2/2011 Time: 6:48 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Compliance with Legal Responsibilities

Online profile:

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

- 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.
- 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) 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) 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.

Page 7 of 7 Date: 2/2/2011 Time: 6:48 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Current Status: Active License Expiration Date: 3/9/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 55 Pond Ave.

Brookline

Massachusetts - 02445 United States of America

Home Address:

Business Address:

55 Pond Ave. Brookline

Massachusetts - 02445 United States of America

(617) 232-0202

3) Email Address:

4) Fax Number: (617) 739-7203

5) Specialties Gynecology

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

ABMS/AOA

Board Name

Certification

Subspecialty

ABMS Obstetrics & Gynecology

Obstetrics and Gynecology

7) Drug License Numbers

Massachusetts

Federal (DEA)

Federal (DEA) XS

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

9) States where you were previously licensed Connecticut

10) Work Sites

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

WorkSite

Location

Beth Israel Deaconess Medical Center

Brigham & Women's Hospital

Page 1 of 5 Date: 2/18/2013 Time: 11:35 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Other

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wk

b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Policy Start Date Controlled Risk Insurance Company of Verm 01/01/2013

Policy End Date

Policy Type

12/31/2013

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, 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?

Page 2 of 5 Date: 2/18/2013 Time: 11:35 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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 your are renewing your license for the first time, please answer Yes)

Yes

Page 3 of 5 Date: 2/18/2013 Time: 11:35 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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?

Page 4 of 5 Date: 2/18/2013 Time: 11:35 PM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Compliance with Legal Responsibilities

Online profile:

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

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

Page 5 of 5 Date: 2/18/2013 Time: 11:35 PM



License No.: 57518 Physician Name: Nina M Carroll, M.D.

Current Status: Active

License Expiration Date: 3/9/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

55 Pond Ave.

Brookline

Massachusetts - 02445 United States of America

Home Address:

Business Address:

55 Pond Ave.

Brookline

Massachusetts - 02445 United States of America

(617) 232-0202

3) Email Address:

4) Fax Number: (617) 739-7203

5) Specialties Gynecology

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

Information

ABMS/AOA

Board Name

Certification

Subspecialty

ABMS

Obstetrics & Gynecology

Obstetrics and Gynecology

7) Drug License Numbers

Massachusetts

Federal (DEA)

Federal (DEA) XS

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

9) States where you were previously licensed

Connecticut

10) Work Sites

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

WorkSite

Location

Beth Israel Deaconess Medical Center

Brigham & Women's Hospital

Date: 2/24/2015 Time: 12:36 AM Page 1 of 5



Physician Name: Nina M Carroll, M.D. License No.: 57518

Other

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 0 hrs/wk

b) outpatient care 18 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Policy Start Date 01/01/2015

Policy End Date 12/31/2015

Policy Type

Claims made with tail coverage

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

14) Claims Made

CRICO

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 taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?

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?

Page 2 of 5 Date: 2/24/2015 Time: 12:36 AM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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 of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes

Page 3 of 5 Date: 2/24/2015 Time: 12:36 AM



Physician Name: Nina M Carroll, M.D. License No.: 57518

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?

Page 4 of 5 Date: 2/24/2015 Time: 12:36 AM



Physician Name: Nina M Carroll, M.D. License No.: 57518

Compliance with Legal Responsibilities

Online profile:

|X| | have reviewed my Physician Profile and confirm that the information is accurate.

- 1) Lunderstand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and Lunderstand 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.
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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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- 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.
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- 12) 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) understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) 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.

Page 5 of 5 Date: 2/24/2015 Time: 12:36 AM

CURRICULUM VITAE of NINA MARIE CARROLL, M.D.

WORK ADDRESS Department of Obstetrics and Gynecology

Boston City Hospital Boston, MA 02118

HOME ADDRESS

CITIZENSHIP United States of America

MARITAL STATUS

POSTGRADUATE EDUCATION

FOURTH YEAR 7/86 to present	Chief Resident. Department of Obstetrics a Boston City Hospital	
THIRD YEAR	Senior Assistant Resident. Department of Obstetrics a	
2/86 to 6/86	Framingham Union Hospital	
7/85 to 1/86	Boston City Hospital	
SECOND YEAR	Junior Assistant Resident . Department of Obstetrics a	
2/85 to 6/85	Malden Hospital	Malden, MA
9/84 to 2/85	Boston City Hospital	Boston, MA
7/84 to 8/84	University Hospital	Boston, MA
FIRST YEAR	Internship. Department of Obstetrics a	nd Gynecology
4/84 to 6/84	Boston City Hospital	Boston, MA
2/84 to 3/84	Department of Medicine Boston City Hospital	Boston, MA
11/83 to 1/84	Department of Obstetrics a Boston City Hospital	nd Gynecology Boston, MA
9/83 to 10/83	Department of Surgical Onc. University Hospital	4.
7/83 to 8/83	Department of Pediatrics Boston City Hospital	Boston, MA

EDUCATION

9/77 to 7/83	Doctor in Medicine, Surgery, and Obstetrics. Awarded on July 20, 1983 with Honors for the 4th doctorate. Faculty of Medicine University of Liege Liege, Belgium
9/74 to 5/76	Premedical Student, Postbaccalaureate. Boston University College of Liberal Arts Boston, MA
9/69 to 12/72	Bachelor of Arts. Awarded in July 1973 with High Honors in PHilosophy Stonehill College North Easton, MA
HONORS	Honors awarded for 4th doctorate year medical school
1970 - 1973	Delta Epsilon Sigma National Scholastic Honor Society
1973	Magna cum laude graduate of Stonehill College
1969 - 1973	Academic scholarship. Stonehill College
WORK EXPERIENCE	
1/77 - 7/77	Paramedical Worker. The International Grenfell Association of Labrador, Canada.
1/75 - 8/75	New England Deaconess Hospital Brookline, MA
1972 - 1976	Assistant Manager. Wamsutta Apartments Company New Bedford, MA Authored an Environmental Impact Statement for this federally funded housing renovation project.
1/73 - 12/73	Seconday School Teacher. Boston Public School System BOston, MA
LANGUAGE	Fluency in conversational and scientific French. Conversational German.
TRAVEL EXPERIENCE	
9/77 - 6/83	Lived in Liege, Belgium travelled throughout Europe.
9/1980	Visited Tuareg nomads of the Sahara Desert in Algeria.
1960 - 1964	Lived in Mannheim, Germany.

REFERENCES AVAILABLE UPON REQUEST.