REDACTED COPY

UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL

APPLICATION FOR SENIOR ELECTIVE

Section I

Student's Name NINA MARIE CARROLL Medical School University of LIEGE, BELGIUM

Mailing Address _____ Year 4th year

Elective(s) Desired:

1. ~~FAMILY MED. CLERK~~ Number ~~601~~ Dates ~~Oct or Nov '82~~ Alternate _____

(2) GYN ONCOLOGY Number 1100 Dates Oct. or Nov. '82 Alternate _____

3. _____ Number _____ Dates _____ Alternate _____

Section II (to be completed by school official at medical school where student is enrolle

This is to certify that the student named above is a student in good standing at this institution and has permission to take the elective indicated above. He or she will be covered by personal liability or malpractice insurance as well as health insurance while at your institution.

Signature R. LAMBOTTE, M.D.

Title DEAN OF THE MEDICAL SCHOOL

Date June 21, 1982

Section III

Your application for the elective indicated above has been:

Approved ✓ Not Approved _____

David A. Sinkel
Dean of Students

Date 9/23/82

You will be expected to report to the following:

1. Person Dr. K. Kearns
2. Place Univ. C. — 4 West
3. Date 10/4/82 Time 6:30 A.M.

Signature _____

Title Chairman 9/20/82

FORM G

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.

I, Kenneth C. Edelin, M.D. (Name), Chief, Department of OB/GYN (Title)

hereby certify that NINA MARIE CARROLL has served 2 1/2 year(s) of post-graduate training as a RESIDENT (Position) in OBSTETRICS + GYNECOLOGY (Specialty) at BOSTON CITY HOSPITAL (Hospital), BOSTON (City), MASS. (State).

This program is ✓ is not ___ approved by the ACGME or the RRC.

Dr. Carroll participated in this program from JUNE (Month), 1983 (Year) to present (Month), 1986 (Year) and was issued ✓ was not issued ___ a certificate as proof of completion of said training. (If not issued a certificate, please explain)

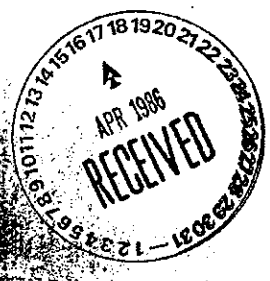
I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no discipiinary action outstanding or pending involving him or her.

Signature of Director

Hospital Seal

4-16-86
Date

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
100 CAMBRIDGE STREET, ROOM 1507
BOSTON, MASSACHUSETTS 02202



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

FORM E

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.

I HEREBY CERTIFY THAT CARROLL, Nina (Name of Applicant) HAS COMPLETED AND ATTENDED FOR seven ACADEMIC YEARS OF INSTRUCTION, OF NOT LESS THAN THIRTY-TWO WEEKS IN EACH ACADEMIC YEAR AT University of Liege(Belgium) (Name of medical school) (Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations in each year):

	FROM: Month	Day	Year	TO: Month	Day	Year
	October	1	1977	July	20	1978
	October	1	1978	July	20	1979
	October	1	1979	July	20	1980
	October	1	1980	July	20	1981
	October	1	1981	July	20	1982
	October	1	1982	July	20	1983

AND HAS RECEIVED THE DEGREE OF M.D. ON July 20 1983.

School Seal

Signature of Dean or Official

P. FRANCHIMONT
Name

Dean
Title

Date: July 18 1985

32

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 19 83

I hereby certify that Miss CARROLL Nina has creditably completed *two years* of a pre-medical course.

From October 1977 To September 1978
Month Day Year Month Day Year

From October 1978 To July 1979
Month Day Year Month Day Year

School Seal

Dean

University of Liège
School

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date May 5th 19 83

I hereby certify that Miss CARROLL Nina has creditably completed at least *three and one-half years* of medical education.

From October 1979 To July 1980
Month Day Year Month Day Year

From October 1980 To July 1981
Month Day Year Month Day Year

From October 1981 To July 1982
Month Day Year Month Day Year

From October 1982 To
Month Day Year Month Day Year

From To
Month Day Year Month Day Year

and ~~has~~ will receive the degree of doctor of Medicine on July 19 83

from ~~University of Liège (Belgium)~~ Surgery and Accouchments
(Name of Medical School)

School Seal

signature of Dean

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

NINA CARROLL

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 _____ 19 ____

I hereby certify that _____ has creditably completed *two years* of a pre-medical course.

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

From _____ To _____
Month *Day* *Year* *Month* *Day* *Year*

School Seal

_____
Dean

_____
School

The DATES ARE correct to the best of my knowledge and should be coming from Faculty of Medicine University of Liege

Nina Carroll M.D.

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date 6/28 1985

I hereby certify that _____ has creditably completed at least *three and one-half years* of medical education.

From ~~September~~ October 10 1978 To July 18 1978
Month *Day* *Year* *Month* *Day* *Year*

From September 29 1978 To July 20 1979
Month *Day* *Year* *Month* *Day* *Year*

From October 6 1979 To July 17 1980
Month *Day* *Year* *Month* *Day* *Year*

From October 1 1980 To July 17 1981
Month *Day* *Year* *Month* *Day* *Year*

From August 4 1981 To July 15 1982
Month *Day* *Year* *Month* *Day* *Year*

July 16 July 20 1983

and has received the degree of ~~Doctor of Medicine~~ on July 20, 1983

from Faculty of Medicine of University of Liege, Belgium
(name of Medical School)

School Seal

_____
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

FORM F

SWORN STATEMENT OF THE DEAN OF THE MEDICAL SCHOOL

Instructions: This form should be completed only by the Dean of the medical school and returned directly to our office. If you attended more than one medical school, this form may be duplicated and forwarded to each school at which you received academic credit.

I, P. FRANCHIMONT (Name of Dean), Dean of Medical Faculty University of Liege(Belgium) (Name of Medical School)

hereby certify that CARROLL Nina (Name of Applicant) was physically present at this institution for the first two years of matriculation in medical school and that he/she successfully completed at least two academic years, of not less than thirty-two weeks in each academic year, including the following courses of basic science study:

- gross anatomy
- biochemistry
- pathology
- physiology
- microbiology
- immunology
- pharmacology

I further certify that Nina CARROLL (Name of Applicant) successfully completed an additional two academic years of not less than thirty-two weeks in each academic year, at this institution of the following courses of study:

- internal medicine
- surgery
- pediatrics
- obstetrics and gynecology
- public health & preventive medicine
- psychiatry

All of Dr. CARROLL 's clinical study was completed at the following hospitals under the onsite supervision and evaluation of the following members of the faculty of this medical school:

Area of Study	Supervisor	Faculty Appointment	Hospital
Internal medicine	H. VAN CAUWENBERGE	full professor	Hôpital universitaire (Bavière)
Surgery	G. LEJEUNE	" "	" "
Pediatrics	F. GEUBELLE	" "	" "
Obsterics/Gynecology	R. LAMBOTTE	" "	" "

continued →

Area of Study	Supervisor	Faculty Appointment	Hospital
Public health and preventive medicine	J.M. PETIT	full professor	Hopital universitaire (Bavière)
Psychiatry	J. BOBON	" "	" "

All clinical study was completed under my direct control and approval. All information contained in this document represents a true statement made under the pains and penalties of perjury.

School Seal

Signature of Dean

Address of School:

59, boulevard de la Constitution

4020 LIEGE

Date: July 18 19 85

Additional comments:

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

FORM F

Commonwealth of Massachusetts
BOARD OF REGISTRATION IN MEDICINE
10 West Street - Second Floor
Boston, Massachusetts 02111

SWORN STATEMENT OF THE DEAN OF THE MEDICAL SCHOOL

Instructions: This form should be completed only by the Dean of the medical school and returned directly to our office. If you attended more than one medical school, this form may be duplicated and forwarded to each school at which you received academic credit.

I, [illegible], Dean of _____, hereby certify that Carroll Nina was physically present at this institution for the first two years of matriculation in medical school and that he/she successfully completed at least two academic years, of not less than thirty-two weeks in each academic year, including the following courses of basic science study:

Name of Dean — Name of Medical School — Name of Applicant

FACULTE DE MEDECINE
SECRETARIAT
DE LA CONSTITUTION, 59
4020 LIEGE

gross anatomy
biochemistry
pathology
physiology
microbiology
immunology
pharmacology

I further certify that Nina Marie Carroll successfully completed an additional two academic years of not less than thirty-two weeks in each academic year, at this institution of the following courses of study:

✓ internal medicine
✓ surgery
✓ pediatrics
✓ obstetrics and gynecology
public health & preventive medicine
✓ psychiatry

All of Dr. Carroll's clinical study was completed at the following hospitals under the onsite supervision and evaluation of the following members of the faculty of this medical school:

Area of Study	Supervisor	Faculty Appointment	Hospital
✓ Internal Medicine	H. Van Cauwenberge H. Culbertus	full professor " "	Hôpital universitaire " "
Internal Medicine	A. Mutsers	Associate professor	Hôpital Val D'Or
Internal Medicine	Van Den Bosch	" "	Hôpital de Bruyères
Surgery	D. Honore	full professor	Hôpital universitaire
✓ Surgery	" " P. Carlier	clinical instructor	" "
Surgery	M. Lifrange	" "	Hôpital de Bruyères
✓ Obstetrics and Gyn	R. Lambotte	full professor	Hôpital universitaire
✓ Pediatrics	R. Jadoul	clinical instructor	Hôpital de Dinant
✓ Pediatrics	A. Mattiva	" "	Hôpital des Anglais
✓ Psychiatry	D. Luminet	associate professor	Hôpital universitaire DE Bavière
	J. Bobon	full professor	

continued →

Commonwealth of Massachusettts
BOARD OF REGISTRATION IN MEDICINE
10 West Street - Second Floor
Boston, Massachusetts 02111

FORM E

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.

I HEREBY CERTIFY THAT Nina Marie Carroll (Name of Applicant) HAS COMPLETED AND ATTENDED FOR six ACADEMIC YEARS OF INSTRUCTION, OF NOT LESS THAN THIRTY-TWO WEEKS IN EACH ACADEMIC YEAR AT University of Liege, Belgium (Name of medical school) (Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations in each year):

	Month	Day	Year		Month	Day	Year
FROM:	October	1	1977	TO:	July	20	1978
FROM:	October	1	1978	TO:	July	20	1979
FROM:	October	1	1979	TO:	July	20	1980
FROM:	October	1	1980	TO:	August	31	1981
FROM:	October	1	1981	TO:	September	26	1982
FROM:	October	1	1982	TO:	July	20	1983

AND HAS RECEIVED THE DEGREE OF M.D. ON July 20, 19 83.

School Seal

Signature of Dean or Official

Name

Date: 17 NOV 1983, 19

Title Dean

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Application Fee: $275.

FLEX EXAMINATION APPLICATION

Filed: _____
By: _____
Form of Fee: _____

FOR OFFICE USE

Application # 58146

Certificate # Date of Issue: _____

PLEASE PRINT OR TYPE

AFFIRM STATEMENT

Date: SEPTEMBER 27, 1984

Name NINA MARIE CARROLL

Mailing Address:

Date of Birth ___ / ___ / ___

Place of Birth NEW BEDFORD, MASS

Name on Birth Certificate NINA Marie Carroll

Phone # _____

Pre-Medical Education

School I attended 6 years of 7 year medical school program

Dates Attended Oct. 1977 – July 1979

Medical Education

School FACULTY OF UNIVERSITY OF LIÈGE MEDICINE

Dates Attended October 1977 – July 1983

POSTGRADUATE TRAINING: (Include all internships, residencies, fellowships, etc.)

Position: RESIDENT OB/GYN Hospital: BOSTON City Hospital FROM: 7/1/83 TO: present

Position: _____ Hospital: _____ FROM: __/__/__ TO: __/__/__

Position: _____ Hospital: _____ FROM: __/__/__ TO: __/__/__

MEDICAL CURRICULUM VITAE: (If applicable)

no

List all other states where you are or have been licensed none

Are you a Diplomate of a Specialty Board? no
(name, if applicable)

	YES	NO
1. Was any medical license ever 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?	_	
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 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

I. 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		Hospital Affiliations
PILGRIM		
HMO Blue	AETNA	Beth Israel Hospital
BCBS (Indemnity)	US	Mount Auburn Hospital
Tufts	STATE HANCOCK	
Other Plans	CIGNA	
	PRU CARE	

II. Education & Training

Medical School: Faculte de Medecine, Universite de l'Etat a Liege
Graduation Date: 1983

Post Graduate Training:

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

FOR OFFICE USE
Date Received _____
Certificate # _____
By: _____ Form of Fee: _____

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: NINA (First) MARIE (Middle) CARROLL (Last) Mailing Address: _____

Date of Birth: ___

Pre-medical School: BOSTON UNIVERSITY Medical School: FACULTY OF MED. UNIVERSITY OF LIEGE BELG.

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?	1.	
2.	Have you ever been denied a medical license?	2.	
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	
4.	Have you ever failed an examination before a State Medical Board?	4.	
5.	Has your privilege to possess, dispense or prescribe controlled substances 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?	6.	
7.	Have you ever been a patient for the treatment of a mental illness?	7.	
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Nina Carroll MD DATE: 4/10/85

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

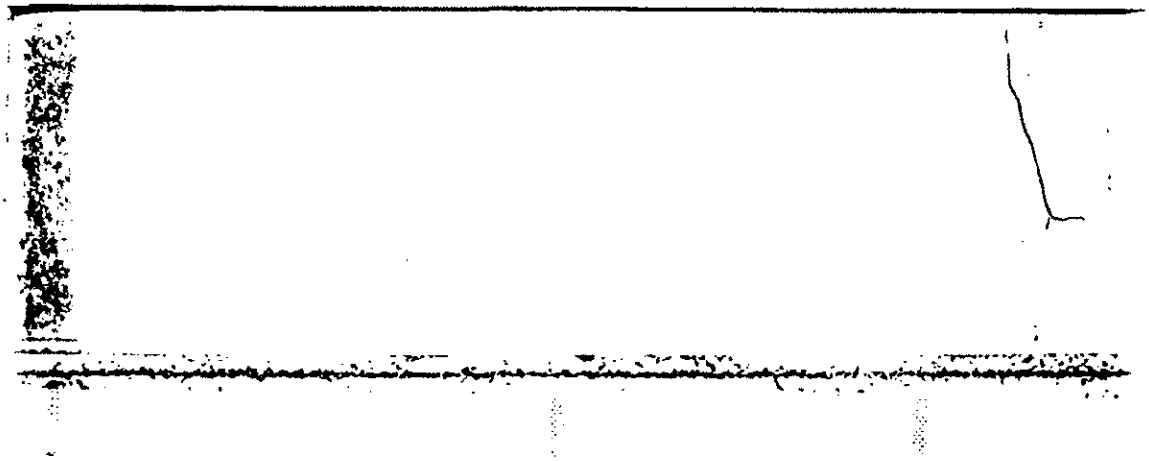
_____ in _____ (Name of Hospital)

beginning _____ and ending _____.

Is the purpose of this application participation in a training program? _____ (yes or no)
If yes, is this program ACGME or RRC accredited? _____ (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? _____ (yes or no)

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

Certified Copy ECFMG Certificate notarized (logged in)

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.

FOR OFFICE USE
Date Received 6/5/86
Certificate # L2059
By: ___ Form of Fee: MO

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: NINA (First) MARIE (Middle) CARROLL (Last)
Date of Birth: ___

Mailing Address: ___

Pre-medical School: Boston University
Medical School: FACULTY OF MEDICINE UNIVERSITY OF LIEGE BELGIUM

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? 87735 (give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?	1.	
2.	Have you ever been denied a medical license?	2.	
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	
4.	Have you ever failed an examination before a State Medical Board?	4.	
5.	Has your privilege to possess, dispense or prescribe controlled substances 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?	6.	
7.	Have you ever been a patient for the treatment of a mental illness?	7.	
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	

RECEIVED MAY 1986

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Nina Carroll 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.

This certifies that NINA MARIE CARROLL has been appointed to the position of PGY-4 SENIOR RESIDENT in BOSTON CITY HOSPITAL (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? YES (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? N/A (yes or no)

Maxine Kessler
Maxine Kessler, Director Physicians Services — 5/27/86
SIGNATURE — OFFICIAL CAPACITY — DATE

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

Approve 6.30.85
E. Moore, MD

THE COMMONWEALTH OF MASSACHUSETTS
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.

FOR OFFICE USE
Date Received 87435
Certificate # ~~87374~~
By: [illegible] Form of Fee: 25 MO

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: NINA (First) MARIE (Middle) CARROLL (Last)

Mailing Address: _____

Date of Birth: _____

Pre-medical School: ① Boston University ② Northeastern Univ.

Medical School: FACULTY OF MEDICINE

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 prescribe, 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?		

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Nina Carroll MD. DATE: 6/25/85

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 Nina M. Carroll has been appointed to the position of Senior Assistant Resident in Boston City Hospital (Name of Hospital) beginning July 1, 1985 and ending June 30, 1986.

Is the purpose of this application participation in a training program? Yes (yes or no) If yes, is this program ACGME or RRC accredited? Yes (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? _____ (yes or no)

Maxine Kessler — Director of Physicians Services — 6/25/85
SIGNATURE — OFFICIAL CAPACITY — DATE

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

PLEASE SEE BROCHURE FOR DATES OF MY MEDICAL EDUCATION. Thank you. Complete form in my application packet except for above dates.

THE COMMONWEALTH OF MASSACHUSETTS
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.	FOR OFFICE USE Date Received ______ Certificate # ______ By: ______ Form of Fee: ______

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: Nina Marie Carrol
First Middle Last

Mailing Address: ______

Date of Birth: ______

Pre-medical School: (1) Stonehill College (2) Northeastern University (3) Boston University

Medical School: Faculty of Medicine University of Liège Belgium

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?		

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Nina Carroll MD DATE: 6/26/85

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)

beginning ______ and ending ______.

Is the purpose of this application participation in a training program? ______ (yes or no)
If yes, is this program ACGME or RRC accredited? ______ (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? ______ (yes or no)

______ ______ ______
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 19 83

I hereby certify that Miss CARROLL Nina has creditably completed two years of a pre-medical course.

From October 1922 To September 1928
Month Day Year Month Day Year

From October 1978 To July 1979
Month Day Year Month Day Year

School Seal

Dean

University of Liège
School

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date May 5th 19 83

I hereby certify that Miss CARROLL Nina has creditably completed at least *three and one-half years* of medical education.

From October 1979 To July 1980
Month Day Year Month Day Year

From October 1980 To July 1981
Month Day Year Month Day Year

From October 1981 To July 1982
Month Day Year Month Day Year

From October 1982 To
Month Day Year Month Day Year

From To
Month Day Year Month Day Year

and will has received the degree of doctor of Medicine on July 19 83

from Surgery and Accouchments
~~University of Liège~~ (Belgium)
(Name of Medical School)

School Seal

signature of Dean

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

Nina CARROLL

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 _____ 19 _____

I hereby certify that _____ has creditably completed *two years* of a pre-medical course.

From _____ (Month / Day / Year) To _____ (Month / Day / Year)

From _____ (Month / Day / Year) To _____ (Month / Day / Year)

School Seal

_____
Dean

_____
School

The DATES ARE correct to the best of my knowledge and should be Carrey Ron Faculty on Medicine University of Liege
Nina Carroll MD

All Medical Graduates

VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION
(to be completed ONLY by the Dean of the School)

Date 6/28 1985

I hereby certify that _____ has creditably completed at least *three and one-half years* of medical education.

From ~~September 29~~ October 10 (Month / Day) 1978 (Year) To July 18 1978

From September 29 1978 To July 20 1979

From October 6 1979 To July 17 1980

From October 1 1980 To July 17 1981

From August 4 1981 To July 15 1982

From July 16 1982 To July 20 1983

and has received the degree of doctor of medicine on July 20, 1983

from Faculty of Medicine of University of Liege, Belgium
(name of Medical School)

School Seal

_____
signature of Dean

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, 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.

FOR OFFICE USE
Date Received _____
Certificate # _____
By: _____ Form of Fee: _____

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: NINA (First) MARIE (Middle) CARROLL (Last) | Mailing Address: _____

Date of Birth: _____

Pre-medical School: BOSTON UNIVERSITY | Medical School: FACULTY OF MED. UNIVERSITY OF LIEGE BELG.

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?	1.	
2.	Have you ever been denied a medical license?	2.	
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?	3.	
4.	Have you ever failed an examination before a State Medical Board?	4.	—
5.	Has your privilege to possess, dispense or prescribe controlled substances 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?	6.	—
7.	Have you ever been a patient for the treatment of a mental illness?	7.	—
8.	Have you ever been under treatment for drug dependency or alcoholism?	8.	—
9.	Has a judgement ever been returned against you in a malpractice suit?	9.	—
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?	10.	—

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Nina Carroll MD DATE: 4/10/85

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)

beginning _____ and ending _____.

Is the purpose of this application participation in a training program? _____ (yes or no)
If yes, is this program ACGME or RRC accredited? _____ (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? _____ (yes or no)

SIGNATURE _____ OFFICIAL CAPACITY _____ DATE _____

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

I. PHYSICIAN INFORMATION

NINA	M	CARROLL	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 57518
License Status Active

First Issue Date 04/22/87

Hospital Affiliation

Beth Israel Hospital
Mount Auburn Hospital

Fenway Cmnty.Hlth.Ctr.
7 Haviland Street
Boston, MA 02115
U.S.A.
(617) 277-3009

Make address corrections here:

617 267-0900

Make any corrections to above here:

Insurance Plan Affiliation:

USHC
TUFTS
HPHC
BCBS, HMO BLUE
Commercial

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No
Accept Medicaid? ☑ Yes ☐ No

II. EDUCATION & TRAINING

Faculte de Medecine, Universite de l'Etat a Liege	MD	83
Medical School	*Degree*	*Date*

Make corrections here

Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*
Residency Program(s)	*Start*	*End*

III. SPECIALTY

Primary Specialty: Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

Final Decisions and orders issued by the Massachusetts Board of Registration in Medicine.

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint .....

.....

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. CARROLL

Date	Amount Paid 0.0000	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

Please enter any peer-reviewed publications to which you have contributed and any awards for community service or professional recognition you have been given.

Awards, Honors	Publications
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....

Note: Please return the survey in the enclosed envelope to:

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

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)

For Office Use

Filed: _____
By: JC (Reg)
Form of Fee: M.O. APPROVED BY BOARD VOTE 4/22/87

Application # 60738
Certificate # 57518
Date of Issue 4/22/87

Please Print **SWORN STATEMENT** Date: 2/10/86

Name NINA (First) MARIE (Middle) CARROLL (Last) Address _____

Date of Birth _____

Place of Birth NEW BEDFORD, MA

Pre-Medical Education

School NORTHEASTERN U. / BOSTON UNIVERSITY

Years Attended 1974 / 1974-1976

Medical Education

School FACULTY OF MEDICINE UNIVERSITY OF LIEGE

Years Attended 1977 - 1983

Postgraduate Education & Hospital Appointments

Place	*Position*	*Dates*
BOSTON CITY HOSPITAL	RESIDENT IN OBSTETRICS And GYNECOLOGY	6/83 to PRESENT

List all other states in which you have been fully licensed: NONE

Other names under which you have been licensed: NONE

List Specialty Boards by which you are certified: NONE

		Yes	No
1.	Was any license ever revoked, suspended, or cancelled?	1.	
2.	Have you ever been denied a license?	2.	
3.	Have you ever been denied the privilege of taking an examination?	3.	
4.	Have you ever failed an examination before any State Basic Science or Medical Board?	4.	
5.	Have you ever been requested to appear before any State Medical Board?	5.	
6.	Have you ever been requested to appear before any Medical Society?	6.	
7.	Have you ever received a warning from a Bureau of Narcotics?	7.	
8.	Have you ever been asked to surrender your Narcotic Stamp?	8.	
9.	Have you ever practiced any other branch of the Healing Arts?	9.	
10.	Have you ever been warned, censured, or requested to withdraw from a hospital staff?	10.	
11.	Have you ever been a patient for the treatment of mental illness?	11.	
12.	Have you ever been under treatment for addiction or insobriety?	12.	
13.	Have you ever appeared for a hearing before a judge or clerk of court with reference to the issuance of a process based on a complaint?	13.	
14.	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?	14.	

If you answered YES to any of the above questions, PLEASE GIVE DETAILS. _____

AMA

TEL 979-7111
Farmington Area Hosp

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)

Filed: 4/23/86
By:
Form of Fee: M.O.

For Office Use

Application # 60738

Certificate # _____ Date of Issue _____

Please Print

SWORN STATEMENT Date: 3/25/86

Name NINA MARIE CARROLL (*First Middle Last*) Address _____

Date of Birth _____

Place of Birth NEW BEDFORD, MA

Pre-Medical Education

School	Years Attended
Northeastern U.	1974
Boston U.	1974-1976

Medical Education

School FACULTY OF MEDICINE UNIVERSITY OF LIEGE

Years Attended 1977 - 1983

Postgraduate Education & Hospital Appointments

Place	*Position*	*Dates*
BOSTON CITY HOSPITAL	RESIDENT in OB/GYN	6/83 to present

List all other states in which you have been fully licensed: NONE

Other names under which you have been licensed: NONE

List Specialty Boards by which you are certified: NONE

		Yes	No
1.	Was any license ever revoked, suspended, or cancelled?	1.	
2.	Have you ever been denied a license?	2.	
3.	Have you ever been denied the privilege of taking an examination?	3.	
4.	Have you ever failed an examination before any State Basic Science or Medical Board?	4.	
5.	Have you ever been requested to appear before any State Medical Board?	5.	
6.	Have you ever been requested to appear before any Medical Society?	6.	
7.	Have you ever received a warning from a Bureau of Narcotics?	7.	
8.	Have you ever been asked to surrender your Narcotic Stamp?	8.	
9.	Have you ever practiced any other branch of the Healing Arts?	9.	
10.	Have you ever been warned, censured, or requested to withdraw from a hospital staff?	10.	
11.	Have you ever been a patient for the treatment of mental illness?	11.	
12.	Have you ever been under treatment for addiction or intoxication?	12.	
13.	Have you ever appeared for a hearing before a judge or clerk of court with reference to the issuance of a process based on a complaint?	13.	
14.	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?	14.	

RECEIVED APR 1986

If you answered YES to any of the above questions, PLEASE GIVE DETAILS. _____

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)

For Office Use

Filed: _____
By: (illegible)
Form of Fee: M.O.

Application # 60738

APPROVED BY BOARD VOTE 4/22/87

Certificate # 57518

Date of Issue 4/22/87

Please Print **SWORN STATEMENT** Date: 2/10/86

Name NINA MARIE CARROLL (First / Middle / Last)

Address _____

Date of Birth _____

Place of Birth _____

Pre-Medical Education

School: Northeastern U. / Boston University

Years Attended: 1974 / 1974-1976

Medical Education

School: FACULTY OF MEDICINE UNIVERSITY OF LIEGE

Years Attended: 1977 - 1983

Postgraduate Education & Hospital Appointments

Place	*Position*	*Dates*
BOSTON CITY HOSPITAL	RESIDENT IN OBSTETRICS And GYNECOLOGY	6/83 to PRESENT

List all other states in which you have been fully licensed: NONE

Other names under which you have been licensed: NONE

List Specialty Boards by which you are certified: NONE

		Yes	No
1.	Was any license ever revoked, suspended, or cancelled?	1.	
2.	Have you ever been denied a license?	2.	
3.	Have you ever been denied the privilege of taking an examination?	3.	
4.	Have you ever failed an examination before any State Basic Science or Medical Board?	4.	
5.	Have you ever been requested to appear before any State Medical Board?	5.	
6.	Have you ever been requested to appear before any Medical Society?	6.	
7.	Have you ever received a warning from a Bureau of Narcotics?	7.	
8.	Have you ever been asked to surrender your Narcotic Stamp?	8.	
9.	Have you ever practiced any other branch of the Healing Arts?	9.	
10.	Have you ever been warned, censured, or requested to withdraw from a hospital staff?	10.	
11.	Have you ever been a patient for the treatment of mental illness?	11.	
12.	Have you ever been under treatment for addiction or insobriety?	12.	
13.	Have you ever appeared for a hearing before a judge or clerk of court with reference to the issuance of a process based on a complaint?	13.	
14.	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?	14	

If you answered YES to any of the above questions, PLEASE GIVE DETAILS. _____

BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC SEC. NUMBER, OPTIONAL ___-___-____

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: ☐
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
		57518	$100		3	9	89	

Nina M Carroll

NOTE! **THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.**

PAYABLE TO:
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.

1. Print Name: Same
2. Date of Birth: ___ (MONTH) ___ (DAY) ___ (YEAR)
3. Medical School: Univ of Liege M.D.? ☐ D.O.? ☐ (Check One.)
4. Country where Medical School located: Belgium
5. Date of Graduation: 1983
6. American Specialty Board Certified? ☐ (Check if yes.)
   Which Boards? ___
7. Principal Specialty(ies): ___
8. Principal work setting: ___
9. Home address: Same
10. Principal business address: ___
11. List all hospitals at which you have currently effective privileges: ___
12. 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 filed 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)?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or 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 recertification 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 REASONABLE 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.

___
SIGNATURE

DATE: ___

(See Reverse Side)

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

FEB 1989 RECEIVED

Board Use Only:

Registration No.	Status	Fee	Renewal Date
57518	1	$150	03/09/89

NINA M CARROLL

M.R. CD
Pr.
Bk. YB 2/6/89
Ch.
D.E. JSW 2/6/89
Fl.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely–***it is not adequate to state that the Board already has the information.**
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records–you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) CARROLL (FIRST:) NINA (M.I.:) M.

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

2. a) Address (Mailing):

2. b) Address (Home):

2. c) Address (Business): 114 WHITWELL ST. Quincy, MA. 02169

2. d) Telephone (Business): (617) 770-3033 Extension 2. e) Telephone (Home) *(Optional)*

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

6. a) Medical School Code *(See Table 1)*: BEL03 *If 99999, write* Name:

6. b) Year Graduated: 1983 6. c) Degree: M.D. ✓ D.O.

6. d) Country: U.S. Canada Code if Other *(See Table 2)*: 15 *If 999, write* Name:

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

10 Hospital	100 %	15 Private Office	%	20 Partnership/Group Practice	100 %
25 Clinic	%	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	%	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

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

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	100 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 4/22/87
30 Administrative Activities	%	40 Medical Teaching	%	
50 Medical Research	%	99 Other	%	

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

10. a) Are you American Specialty Board Certified? (Y/N) N *10. b) If YES, circle which Board(s):*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	OG	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*
Facility Code: 151 100 % Facility Code: % Facility Code: %
Facility Code: % Facility Code: % Facility Code: %

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*
Facility Code: 307 Facility Code: 084 Facility Code: 041 Facility Code: 020 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: Nina Carroll Date: 2/2/89

(See reverse side)

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

Fill in name and number. **Physician Last Name:** CARROLL **Registration No.:** 57518

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

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

13. I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 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.U.A. Institution Issuing Letter of Credit: ____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* ____

14. c) Percent of Practice Time in Massachusetts: 100 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):*		

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

Registration No.	Status	Fee	Renewal Date
57518	ACTIVE	$150	03/09/91

Dr. NINA M CARROLL

For Office Use Only

M.R. 2/19/91
Pr.
Bk. FEB 19 1991
Ch.
D.E. 12/19/91

Directions:

- *Questions 1-7 include information from Board files. Please correct it as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:

I am applying to be registered with the following status: Active X Inactive ____

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

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

2. a) Address (Home):

2. b) Address (Business):
114 WHITTELL STREET
QUINCY, MA 02169-

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

3. Date of Birth: Sex: F
Lic. Issue Date: 04/22/87 SSN #:
Telephone Number:
Home ( ) -
Business (617)770-3033

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

4. Medical School Code: BELO3 Year Graduated: 83 Degree: MD
Name of School:
Faculte de Medecine, Universite de l'Etat a Liege

School Code: ____ Year Graduated: ____ Degree (MD/DO): ____
If 99999, write School: ____

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

NONE
CT

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

Code	Hours per Week in Mass.	
330	30	Obstetrics and Gynecology

Code	Hours per Week in Mass.
OBG	24-30

If OS, write specialty: ____

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

Code: ____
Code: ____

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) ____ b) How many DEA nos. do you have? ____
c) State (MA) #M ____

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

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

FILL IN NAME AND NUMBER:
Physician Last Name: CARROLL Registration No.: 57518

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

List Insurer: JUA

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

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

(State how otherwise exempt):_____

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

Facility Code: 151 /✓(AP) Facility Code: ___ ___ ___ /__(AP) Facility Code: ___ ___ ___ /__(AP)

Facility Code: ___ ___ ___ /__(AP) Facility Code: ___ ___ ___ /__(AP) Facility Code: ___ ___ ___ /__(AP)

If 999, write Name(s):_____

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

Facility Code:___ ___ ___ 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? Yes____ No 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.

14. Principal Work Setting.
    a) What is your principal work setting? (*See Table 6*) 20

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A.
Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or [illegible] criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?		

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

Pursuant to M.G.L. c.62C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.

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

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

Signature: Mira Carroll MD Date 2 / 15 / 91

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
27515	ACTIVE	$250.00	03/09/93	$25.00

Mailing Address:
NINA M CARROLL, M.D.

Correction of Mailing Address:
Address (Mailing): _____
City/Town: _____
State: _____
Country Code (See Table 1): _____

Directions: **Staple check to bottom of form. Add late fee if necessary.**
- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page.
- Before proceeding, please read the instruction booklet. Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- Enclose the $250.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. E
Pr. [illegible]
Bk/D.E. 3/9/93 O.K.

Pre-Printed Information

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

2. a) Address (Home):

b) Address (Business):
114 WHITWELL STREET
QUINCY, MA 02169

3. Date of Birth: Sex: F
Lic. Issue Date: 04/22/87 SS#:
Telephone Number:
Home ( ) - Business (617)770-5033

4. Name of Medical School:
Faculte de Medecine, Universite de l'etat a Liege
Year Graduated: 83 Degree: MD

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

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

Code	Hours per Week in Mass.
008	30

Obstetrics and Gynecology

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

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

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

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): WOMEN-CARE, INC. 02174
City/Town: 180 MASS. AVE. ARLINGTON, MA
Country Code: 0 If 999 print Country: _____

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#:
Telephone Number:
Home: _____ Business: (617) 648-4221

Full Name of Medical School: _____

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

NONE
CT

Code	Hours per Week in Mass.
O B G	50

If OS, print specialty: _____

Code: OG Code: _____

Code: _____ Code: _____

Federal (DEA):
State (MA): _____

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: CARROLL Registration Number: 57518

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

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

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

List Insurer: JUA

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: 108 / ✓ (AP) Facility Code: 41 / ✓ (AP) Facility Code: 60 / ✓ (AP)

Facility Code: 38 / ✓ (AP) Facility Code: 71 / ✓ (AP) Facility Code: 996 / ____ (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: 151 Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write name(s): ____

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

14. a) What is your principal work setting? (See Table 5) 15

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? 32 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 6+ hrs/wk in MA

Questions 15 through 23 refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

	YES	NO
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
16. Have you been charged with any criminal offense, other than a minor traffic violation?		
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?		
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?		

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**

- **Pursuant to G.L. c. 62C, sec. 49A, I hereby certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.**

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

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

Signature: Anna Carroll MD Date: 3/3/93

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

Registration No.	Status	Fee	Renewal Date	Late Fee
57518	ACTIVE	$250.00	03/09/95	$25.00

Mailing Address:

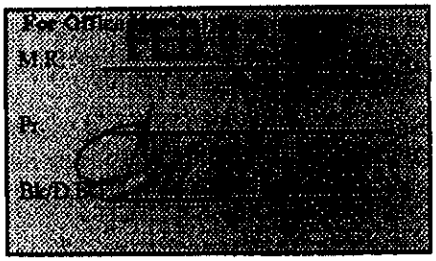
NINA M CARROLL, M.D.
1224 BOYLSTON STREET
CHESTNUT HILL, MA 02167

Correction of Mailing Address

Address (Mailing): _____
_____
City/Town: _____
State: _____
Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- **Add late fee if necessary.**
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.



Pre-Printed Information

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

2. Home Address:

3. Date of Birth: Sex: F
   Lic. Issue Date: 04/22/87 SS#:

   Home Phone: Business Phone: 617) 648-4221

4. Name of Medical School:
   Faculte de Medecine, Universite de L'Etat a Liege
   Year Graduated: 83 Degree: MD

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.	
OBG	50	Obstetrics and Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: OG Code:

8. Drug license number(s), if any: a) Federal (DEA)
   b) Massachusetts

Corrections of Pre-Printed Information

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

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

Home: ( ) _____ Business: (617 277-3119

Full Name of Medical School: _____
_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
G Y N	50

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: 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: CARROLL Registration Number: 57518

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 69 / ✓(AP) Facility Code: ___ / ___(AP) Facility Code: ___ / ___(AP)

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

If 999, print name(s): ___

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

Facility Code: 41 Facility Code: 60 Facility Code: 38 Facility Code: 108 Facility Code: ___

If 999, write name(s): ___

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

List Insurer: CRICO

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

State how otherwise exempt: ___

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

13. a) What is your principal work setting? (See Table 4) 15

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? 45 hrs/wk

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.) 100 %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested ___ No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: Mary Carroll MD Date: 1/24/95

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.
- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Registration No.: 57518 Renewal Date: 03/09/97

ELN

1. Activity Status: (Check only one)
   - ☑ Active
   - ☐ Inactive *(see below)
   - ☐ Retiring (see instructions)
   - ☐ Do not wish to renew

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

3. A) Mailing

NINA M CARROLL, M.D.
1224 BOYLSTON ST
CHESTNUT HILL, MA 02167-2104

B) Home Address:

Home Phone:
Business Phone: (617)277-3119

4. A) Date of Birth:
   B) Lic. Issue Date: 04/22/87
   C) Sex: F
   D) SS#:

5. A) Name of Medical School:
   Faculte de Medecine, Universite de l'Etat a Liege
   B) Year Graduated: 83 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
GYN	50	Gynecology

Corrections (type or print) 3/3

Other Name(s):

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

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

Home: ( )
Business: ( )

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

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code(s) Hours Per Week in Mass.

If OS, Print Specialty:

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

Code: Code:

8. Drug License Numbers, if any:
   A) Federal (DEA):
   B) Massachusetts:

Federal (DEA):
Mass:

9. A) Other states where you are now licensed to practice
   Abbr:
   B) States where you previously were licensed to practice
   Abbr: CT

Abbr:

Abbr:

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

LLS

PRINT NAME AND NUMBER: Last Name: CARROLL Registration Number: 57518

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).

Facility Code: 69 /__(AP) Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP)
Facility Code: 71 /__(AP) Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP)
If 999, print name(s): _____

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

Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __

If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) X Insurance Carrier ____b) Letter of Credit

Name of Insurer: CRICO

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 50 hrs/wk b) inpatient care 4 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 0 %

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ *Waiver requested* (*waiver form due 30 days prior to date of license expiration*). ☐ *Training Program exemption*		

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

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature _____ Date: 2/22/97

Massachusetts Board of Registration in Medicine
Physician Profile

NINA M. CARROLL, MD

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

I. 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: ~~B.I. HEALTHCARE\ STE 311~~
25 ~~BOWLECTON~~ BOYLSTON STREET
CHESTNUT HILL, MA 02167-
Phone: 617-277-3119

Translation services available: None

Insurance Plans Accepted

HMO Blue
BCBS (Indemnity)
Tufts
PILGRIM
AETNA
US HEALTHCARE
STATE HANCOCK
CIGNA
PRUCARE
OTHER PLANS

Hospital Affiliations

Beth Israel Hospital
Mount Auburn Hospital

II. Education & Training

Medical School: Faculte de Medecine, Universite de l'Etat a Liege
Graduation Date: 1983

Post Graduate Training:

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

A. 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.

B. 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

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.

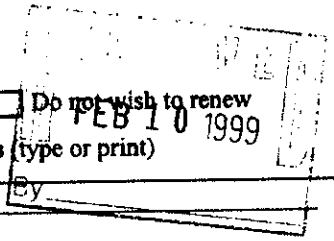
- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

- **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: 03/09/1999 1. Current Status: Active

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

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



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

3. A) Mailing
NINA M CARROLL, M.D.
B.I. HEALTHCARE\ STE 311
25 BOYLESTON STREET
CHESTNUT HILL, MA 02167

B) Home Address:

Home Phone:
Business Phone: (617)277-3119

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

5. A) Name of Medical School:
Faculte de Medecine, Universite de l'Etat a Liege
B) Year Graduated: 1983 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
GYN	50	Gynecology

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

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts:

9. A) Other states where you are now licensed to practice
Abbr:
B) States where you previously were licensed to practice
Abbr: CT

Please make corrections (type or print)

Other Name(s): _____

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

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

Home: (____)_____
Business: (____)_____
Date of Birth: (M/D/Y): __/__/__ Sex : ☐ M ☐ F
SS#: __ __ __ - __ __ - __ __ __ __
Full Name of Medical School:
_____
_____
Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: CARRICO Registration Number: 4 1 5 1 2

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility.

Facility Code: 4 4 1 / ___ (AP) 100 % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %

Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ / ___ (AP) ___ %

If 999, print name(s): ___

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

Name of Insurer: CRICO Alternatively, indicate as follows:

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

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

Please explain exemption: ___

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 5 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ Training Program exemption

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

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: Mira Carrico Date: 2 / 4 / 99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

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

Physician Registration Renewal Application

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

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

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

1. Current Status: Active | Registration No.: 57518 | Renewal Date: 03/09/2001

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

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

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

A) Mailing/Business Address:

3. NINA M CARROLL
1400 Centre St
Suite 206
Newton Centre, MA 02459

B) Home Address:

RECEIVED
FEB 26 2001
BOARD OF REGISTRATION IN MEDICINE

Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

Business Address: _____
City/Town: _____ State: ____
Zip: _____ Country: _____
Business Telephone: (617) 630-9800

Home Address: _____
City/Town: _____ State: ____
Zip: _____ Country: _____
Home Telephone: (____) _____

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

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

c) SS#:

5. a) Name of Medical School: Faculte de Medecine, Universite de l'Etat a Liege
b) Year Graduated: 1983 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) OYN 0 Hours per Week in Mass.
0 Gynecology

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.)
____ ____ ____ ____ ____ ____ ____

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

10. Current health care facilities at which you have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility).

Facility Code: 441 ✓ (AP) 25 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: 711 ✓ (AP) 10 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: CARROLL LICENSE NUMBER: 57518

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Controlled Risk Insurance Co, of VT. Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No
13. A. What is your principal work setting? (See Table 4) 1 5
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 10 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: Mara Carroll Date: 2/14/01

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

NINA CARROLL

PHYSICIAN PROFILE

(Information current as of 8/21/96)

Nina *M.* *Carroll*

I. PHYSICIAN INFORMATION

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

Please Add :

Fenway Comm.Hlth.Ctr.
7 Haviland Street
Boston, MA 02115
U.S.A.
(617) 267-0900

BETH ISRAEL
OB/GYN FOUNDATION
25 BOYLSTON STREET
CHESTNUT HILL, MA
02167
617 277-3119

Insurance Plan Affiliations

Hmo Blue
Bcbs (Indemnity)
Tufts
Other Plans

Hospital Affiliations

Beth Israel Hospital
Mount Auburn Hospital

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

II. EDUCATION AND TRAINING

Medical School: *Faculte De Medecine, Universite De L'Etat A Liege 83*
Post-Graduate Training:

III. SPECIALTY / BOARD CERTIFICATION

SPECIALTY	BOARD CERTIFICATION
Gynecology	*Board Of Obstetrics And Gynecology*

IV. HONORS AND AWARDS

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

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

Physician Registration Renewal Application

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

- Remit $400.00 for renewal fee (non-refundable).
- Add late fee of $25.00, if necessary.
- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

1. Current Status: Active Registration No.: 57518 Renewal Date: 03/09/2003

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

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

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

3. A) Mailing/Business Address:
NINA M CARROLL
1400 Centre St
Suite 206
Newton Centre, MA 02459

B) Home Address:

Home Phone:

Business Phone: 617 630-9800

Please make corrections (print)

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

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

2nd
Business Address: 55 POND Avenue
City/Town: BROOKLINE State: MA
Zip: 02146 Country: USA
Business Telephone: (617) 232-0202

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

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

4. a) Date of Birth: b) Sex: F
c) SS#:

5. a) Name of Medical School:
Faculte de Medecine, Universite de l'Etat a Liege
b) Year Graduated: 1985 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
GYN	0	Gynecology

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

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

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

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

Facility Code: 441/✓ (AP) 10 % Facility Code: 711/✓ (AP) 45 % Facility Code: ___/___ (AP) ___ %
Facility Code: 921/✓ (AP) 45 % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: CARROLL LICENSE NUMBER: 57518

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

Insurer's name. (Required): CRICO Policy dates: From: 1/1/03 To: 12/31/03

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 21 hrs/wk B) outpatient care 50 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. **CLAIMS MADE (New or Pending):** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS (Resolved):** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
18. Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: Mira Carroll Date: 2/10/03

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL **License No.:** 57518

PART A

1) Current Status: Active **Renewal Due Date:** 02/09/2005 **Birth Date**

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

☒ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

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

RECEIVED JAN 31 2005 Board of Registration in Medicine

2a) MAILING ADDRESS

55 pond Ave.
Brookline, MA 02445

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☒ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

55 pond Ave.
Brookline, MA 02445

Phone: (617)232-0202

☐ *Check here to change this address*

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (___)_____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617 739-7203

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**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.)*

List Certifying Board(s) below:

Board Name	**ABMS or AOA**		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
			Certificate/Subspecialty	**Correct?**	**Delete?**
	☒	☐	Obstetrics & Gynecology	☒	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Massachusetts Physician Renewal Application

Physician Name: *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 <u>now</u> licensed to practice (Abbr.)**
a) Massachusetts:	
b) Federal (DEA):	**8b) States where you were <u>previously</u> licensed (Abbr.)**
c) Federal (DEA) XS:	CT

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

Principal Work Setting: Private Office

Change to: _____ Hours per Week: 32

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 ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category		# Hours per Week
		Current	Change	
Beth Israel Deaconess Medical Center	☐	ACTIVE		2-3
Brigham & Women's Hospital	☐	ACTIVE		1-2
Mount Auburn Hospital	☐	COURTESY		<1
WOMEN'S HEALTH SERVICES	☐	CONSULTING		6-8
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 21 hrs/wk Change to: <1 hrs/wk

b) outpatient care 50 hrs/wk Change to: 40 hrs/wk

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

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

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2005 To 12/31/2005 *(required)*

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

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

Check one:

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

Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL **License No.:** 57518

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* If Yes, please complete Form PCA-O "Office Based Surgery"	**Yes**	**No**

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

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

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

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

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

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

Massachusetts Physician Renewal Application

Physician Name: NINA M CARROLL **License No.: 57518**

PHYSICIAN PROFILE

☐ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☒ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 10.*)

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Nina Carroll Date: 1/28/05

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

Massachusetts Physician Renewal Application

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

01/16/07 01:21

PART A

1) Current Status: Active **Renewal Due Date:** 02/09/2007 **Birth Date:**

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

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

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

55 Pond Ave.
Brookline, MA 02445

RECEIVED
JAN 11 2007
Board of Registration in Medicine

☐ *Check here to change this address*

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

55 pond Ave.
Brookline, MA 02445

Phone: (617)232-0202

☐ *Check here to change this address*

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617-739-7203

Correct your E-mail and Fax Number below:

_____

_____

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.)

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: 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:		CT

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Beth Israel Deaconess Medical Center	BOSTON	MA	☐
Brigham & Women's Hospital	BOSTON	MA	☐
Mount Auburn Hospital	Cambridge	MA	☐
Other			☐
Women's HEALTH SERVICES	CHESTNUT HILL	MA	☐
FOUR WOMEN	ATTLEBORO	MA	

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

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

b) outpatient care 40 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2007 To 12/31/2007

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

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

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

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

Check one:
- ☐ Not involved with direct or indirect patient care in Massachusetts
- ☐ A Government Employee under Federal Tort Claims Act (FTCA)
- ☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

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

Massachusetts Physician Renewal Application

Physician Name: 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? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

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

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

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

Massachusetts Physician Renewal Application

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

PART C

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.)
- [ ] 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: Nina Carroll Date: 1/9/07

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

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, 2007.**

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

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

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

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 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 authorize BORIM to apply for an NPI on your behalf.

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 6 7 V G 0 4 0 0 X	OBSTETRICS + GYNECOLOGY - GYNECOLOGY
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): MASS Country of Birth (if outside the US): _____

Gender: ☐ Male ☑ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: Nina Carroll Date: 1/9/07

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

Massachusetts Physician Renewal Application

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

PART A

1) Current Status: Active **Renewal Due Date:** 02/09/2009 **Birth Date:**

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

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

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

2a) MAILING ADDRESS
55 Pond Ave.
Brookline, MA 02445

RECEIVED
FEB 09 2009
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: (___)_____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
55 pond Ave.
Brookline, MA 02445

Phone: (617)232-0202

☐ *Check here to change this address*

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (___)_____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617-739-7203

Correct your E-mail and Fax Number below:

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.)

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: 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:		CT

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Beth Israel Deaconess Medical Center			☐
Brigham & Women's Hospital			☐
Mount Auburn Hospital			☒
Women's Health Services	CHESTNUT HILL	MA	☐
			☐

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

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

b) outpatient care 40 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2009 To 12/31/2009

Type of Policy: ☑ Claims made with tail coverage ☐ Occurrence Policy

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt *(Please explain)*: _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**

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

Massachusetts Physician Renewal Application

Physician Name: 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? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☑ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☑ **No**

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

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

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

Massachusetts Physician Renewal Application

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

02/19/09 $1 17 39

PART C

Check One: **PHYSICIAN PROFILE**

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

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 11.)

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: N Carroll Date: 2/2/09

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: 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)	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	

Other
Women's Health Services,PC. Brookline, MA

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	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?

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

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?

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

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physical to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **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.**

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: 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	

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	Policy End Date	Policy Type
Controlled Risk Insurance Company of Verm	01/01/2013	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?

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

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?

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a 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) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **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.**

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

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

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 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	

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	Policy End Date	Policy Type
CRICO	01/01/2015	12/31/2015	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 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?

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

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?

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

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a 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) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **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.**

[X] **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.**

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	Chief Resident.	
7/86 to present	Department of Obstetrics and Gynecology	
	Boston City Hospital	Boston, MA
THIRD YEAR	Senior Assistant Resident.	
	Department of Obstetrics and Gynecology	
2/86 to 6/86	Framingham Union Hospital	Framingham, MA
7/85 to 1/86	Boston City Hospital	Boston, MA
SECOND YEAR	Junior Assistant Resident.	
	Department of Obstetrics and Gynecology	
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 and 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 and Gynecology	
	Boston City Hospital	Boston, MA
9/83 to 10/83	Department of Surgical Oncology	
	University Hospital	Boston, MA
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	Nursing Assistant. 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.