CN 119279

Initial Medical Licensure
PERSONAL INFORMATION
10/2009 INT

STOP! Completed application and check must be mailed to:
MARYLAND BOARD OF PHYSICIANS
P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-1298 Toll Free: 800-492-6836

APPLICATION FOR INITIAL MEDICAL LICENSURE

FOR BANK USE ONLY
Date
Check Number 375
Amt. Paid 790
Name Code
Appl ID 17

RECEIVED
MAR 21 2014
MARYLAND BOARD OF PHYSICIANS

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. **Your Complete Current Legal Name:** As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.):
NATHAN

First name and middle name:
SACHEEN

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name
CARRELLIS

Stop! **If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.**

2. **Public Address:** Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: **If you change your address prior to being licensed, immediately notify the Board in writing.**
210 LINCOLN STREET

City: BOSTON State: MA Zip Code: 02111-

3. **Non-Public Address:** This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.

Street Address: **(Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.**
[redacted]

City [redacted] State [redacted] Zip Code [redacted]

4. **Telephone (s):** Home - -

Office: - -

Cell/Pager: [redacted]

E-mail address: [redacted]

5. **Date of Birth:** Month Day Year [redacted]

6. **Gender:** [redacted]

7. **Race:** Multiracial applicants may select all applicable categories [redacted]

Ethnicity: [redacted]

8. **Social Security Number:** [redacted]

For Board Use Only

License Number: D77891
Date Issued: 05/22/14
BPQA School Code: 035003
Federation School Code: 033010

Licensed By: L. Dorsey Licensing Exam: USMLE

9. Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	05	99

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity:
07	99	TO	06	03	Residency in OB/GYN

Address: 1901 1st Avenue New York NY

month	year	TO	month	year	Activity:
07	03	TO	03	14	Faculty Boston University Medical Center

Address: 850 Harrison Avenue Boston MA 02118

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

month	year	TO	month	year	Activity:
		TO			

Address:

CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Initial Medical Licensure
CHRONOLOGY
10/2009 INT

Print Your Name: Sacheen Nathan Date: 3-14-14

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages.

month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
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month	year	TO	month	year	Activity:
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month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:

10. **MEDICAL EDUCATION: List all medical schools you have attended** **From: MM/YY To MM/YY**

Albany Medical College 07/95 to 06/99

Medical School From Which You Received Your Medical Degree: Albany Medical College

Name of University Affiliation (if applicable): * Union University

Street Address: 47 New Scotland Ave Albany NY 12208

City: Albany **State/Province:** NY **Country of citizenship during medical education:** USA

Language(s) of Instruction: ~~Not~~ English

Type of Degree: ☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other:_____ (specify)

Date Degree The date you officially received your degree after all prerequisite obligations, required training, government service, etc.

Was Conferred: was satisfied. Month 05 Day 27 Year 99

GRADUATES OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada)
Attach the following documents to this application:

1) **A copy of your valid ECFMG certificate or Fifth Pathway Certificate;**

2) **A copy of your medical school diploma and a certified translation;**

3) **If you listed an affiliation above (see * in 10 above), attach a copy of the Certificate of Medical Education and Examinations Taken, Good Conduct Certificate or Intern Certificate. The certificate must include your name, name of the medical school, name of the university, and a certified translation.**

If your name is not written the same way on all documents, you must submit documentation to explain how and why your name differs and submit one of the following documents to support the name change: Passport, INS card, birth certificate, court document, marriage license, court decree.

11. **How have you satisfied Maryland's *written and oral* English language competency requirements?**
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☒ I graduated from a medical school **or**, after at least three years of attendance, a high school (includes GED), undergraduate college, or university **where English was the *only* language of instruction throughout** (you must provide documentation); **or**

b. ☐ I passed either ☐ the TOEFL **or** ☐ the ECFMG English test after December 31, 1973 **AND** I passed the ☐ TSE or ☐ OPI. If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board;

c. ☒ I passed the USMLE Step 2 Clinical Skills Exam.

Are you claiming speech impairment? ☒ NO ☐ YES If "YES," please write or call the Board for additional information.

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE.) List in chronological order **ALL** postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education *after* successfully completing a Board approved Fifth Pathway program. If you have not met these two critera, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #s	Place of Training:	Specialty:	month / year TO month / year	Accredited by:
1-4	Metropolitan Hospital / NY Medical College ~~University~~		06 / 99 TO 06 / 03	
	Address:			ACGME ☒ AOA ☐ RCPSC ☐
PG Year #s	Place of Training:		month / year TO month / year	
	Address:	Specialty:		Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training:		month / year TO month / year	
	Address:	Specialty:		Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training:		month / year TO month / year	
	Address:	Specialty:		Accredited by: ACGME ☐ AOA ☐ RCPSC ☐
PG Year #s	Place of Training:		month / year TO month / year	
	Address:	Specialty:		Accredited by: ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

13. **Hospital Privileges After Postgraduate Training:** Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition.

Hospital:	month / year TO month / year
Boston University Medical Center	07 03 TO 03 14
Complete Address: 850 Harrison Avenue Boston MA 02118	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
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Hospital:	month / year TO month / year
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Hospital:	month / year TO month / year
Complete Address:	Department
Hospital:	month / year TO month / year
Complete Address:	Department

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

a. Have you ever failed any medical licensing examination (or part, step, or component thereof)? [redacted]

b. Have you failed any medical licensing examination (or part, step, or component thereof) three or more times? [redacted]

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement.

IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORETHAN 3 TIMES, You may not be eligible for medical licensure in Maryland. For a complete explanation see COMAR 10.32.01.03 Licensure—Qualifications for Initial Licensure

a. **State Board Examination List state(s):**_____

STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.

Send a copy of MBP IML7, *State Board Licensure and Examination Certification,* form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board prior to sending form IML7, as all fees are the responsibility of the applicant.**

Federation of State Medical Boards (See Page 8 if you took a combination of these exams or combined either with the NBME exams)

b. ☐ FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. ☐ FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. ☒ USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. ☐ **National Board of Medical Examiners** (See Page 8 if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification *and* the Record of Scores. All requests must be made through the NBME website at **http://www.nbme.org** or call 215-590-9592. If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. ☐ **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.** If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. ☐ **Medical Council of Canada**

Licentiate of the Medical Council of Canada

Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

CONTINUED ON PAGE 8

Print Your Name: Sacheen Nathan Date: 3-14-14

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

h. ☐ USMLE 1 + NBME II + NBME III

i. ☐ USMLE 1 + USMLE 2 + NBME III

j. ☐ USMLE 1 + NBME II + USMLE 3

k. ☐ NBME I + USMLE 2 + USMLE 3

l. ☐ NBME I + USMLE 2 + NBME III

m. ☐ NBME I + NBME II + USMLE 3

n. ☐ FLEX 1 + USMLE 3

o. ☐ FLEX 2 + USMLE 1 + NBME II

p. ☐ FLEX 2 + USMLE 1 + USMLE 2

q. ☐ FLEX 2 + NBME I + USMLE 2

r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at **http://www.nbme.org** or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Maryland Board of Physicians.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☐ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states:_____, _____, _____, _____, _____

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☒ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked
Massachusetts	216743	X					

(If more space is needed, please attach an additional signed and dated sheet.)

RELEASE AND CERTIFICATION

19. Release:

I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for medical licensure in Maryland from any person or agency, including but not limited to postgraduate program directors, individual physicians, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, the Federation of State Medical Boards, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

Sacheen Nathan (maiden name Carr-Ellis) — Applicant's Name (Printed)

[signature] — Applicant's Signature

3-14-14 — Date

20. (OPTIONAL) Third Party Release: Although the Board encourages you to complete all aspects of your application on your own, if you plan to use an intermediary to receive information about the status of your application, please complete this release.

I agree that the Maryland Board of Physicians may release any information pertaining to the status of my application to the following person:

Name: _____

Phone: _____

Applicant's Signature — Date

21. I agree that I will cooperate fully with any request for information or with any investigation related to my medical practice as a licensed physician in the State of Maryland, including the subpoena of documents or records or the inspection of my medical practice.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under Md. Code Ann., Health Occ. § 14-404.

[signature] — Applicant's Signature

3-14-14 — Date

22. Affidavit: To be completed by the applicant in the presence of a notary public after the applicant's picture has been attached below.

I certify that I have personally reviewed all the responses to items 1-22 of this application and that the information I have given is true and accurate to the best of my knowledge. I understand and agree that I may not practice, attempt to practice, or offer to practice medicine in Maryland unless licensed by the Board.

[signature] — Applicant's Signature

3-18-2014 — Date

STATE OF Massachusetts

CITY/COUNTY OF Suffolk

I HEREBY CERTIFY that on this 18 day of March, 20 14, before me, a Notary Public of the State and City/County aforesaid, personally appeared the Applicant, Sacheen Nathan (print applicant's name), whose likeness is identifiable as that of the person in the photograph attached to this application and who has made oath in due form of law to be the person referred to in the above application for license to practice Medicine and Surgery in the State of Maryland, and to have stated the truth in all statements made in this application.

AS WITNESS my hand and notorial seal. Aaron Myers — Notary Public

My Commission expires: 5/26/2017

SEAL

AARON MYERS
Notary Public
COMMONWEALTH OF MASSACHUSETTS
My Commission Expires
May 26, 2017

STOP! Completed application and check must be mailed to Maryland Board of Physicians, P.O. Box 37217, Baltimore, Maryland 21297

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Print

Application for renewal of: **Physicians**

1. **License Number D0077891** Dr. Sacheen Nathan

Individual National Provider Identifier NPI: 1033192471 ☐ I do not have an NPI or I cannot find my NPI

2. This is the NPI entered in the field for Rendering NPI on a claim (10 digit number)

Search NPI: https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do

3. EMAIL ADDRESS: Please enter your most current email address where we may contact you regarding your license.

[redacted]

Address Changes (Non-Public and Public):

You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2015. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street [redacted]
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country

4b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street .7648 Belair Road
Street (2)
Street (3)
City Baltimore
State Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 21236
Country United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2013. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.

[redacted]

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

[redacted]

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or

an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

[redacted]

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

(•) **a. CME met *.** I have earned at least 50 credit hours of Category I continuing medical education (CME) during the two-year period immediately preceding the submission of my application for license renewal.

( ) **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. See New Physician Orientation Program web site. **The Board will not renew your license unless you have completed the orientation.**

( ) **c. First Renewal after reinstatement.** The CME requirement does not apply to me during this renewal period because this is my first renewal after reinstatement of my medical license.

** The Board may impose a fine of up to $100 per CME credit for failure to obtain the required CME credits.*

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gende[redacted]

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) [redacted]

Select one or more of the following racial categories:

[redacted] American Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, and who maintains tribal affiliations or community attachment.)

Asian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

Black or African American (A person having origins in any of the black racial groups of Africa.)

Native Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Other

[redacted]re you employed by the Federal Government?

( ) Yes (•) No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer ***Yes*** to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

( ) Yes (•) No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ● No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Obstetrics & Gynecology

Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: Obstetrics & Gynecology

Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☑ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☑ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☐ Virginia
☐ Arkansas	☐ Hawaii	☑ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☐ Illinois	☐ Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	☑ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ District of Columbia	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 30

13b. Please indicate below how the hours are allocated in your typical work week . The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes the teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	40	hours per week
b. Research	4	hours per week
c. Teaching	0	hours per week
d. Administration & Other	4	hours per week
Total Hours	48	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next two years?

Yes No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

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16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 0

If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

○ Yes ○ No ○ Don't know

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17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 0

b. Number of hospitals outside of Maryland (if none, enter 0) 1

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18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Whole Women's Health

Organization Name2:

b. Street Address: 7648 Belair Road

c. Street2:

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Baltimore

e. State: Maryland

f. Zip Code: 21236

g. Jurisdiction: BALTIMORE COUNTY

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h. Employer Tax ID: 20 - 3757231 If you do not have an EIN enter 00-0000000

What is Employer tax ID?

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i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter > Organizational NPI

◉ I use my Individual NPI for billing.

○ I do not bill public or private insurers.

○ I can not find my Organizational NPI.

---

j. You indicated in Question 13a, **40** hours of Patient Care Related Activities during a typical work week.

How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location?

If none, enter 0. 5 Hours

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k. Setting: Other Clinic

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group-independent

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.

- If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. 3

Number of mid-level medical providers at this location. 0

- Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

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19. Secondary Practice / Office Location

No Secondary Location indicated from your response in Question 16.

- If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

20-21 The Health Information Technology questions have been moved to a separate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. (●) Yes ( ) No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) (●) Yes ( ) No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? (●) Yes ( ) No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? (●) Yes ( ) No

c1. If **Yes**, are you accepting new Medicare patients? (●) Yes ( ) No

---

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

(●) Yes ( ) No ( ) NA

23a. Do you participate in a value-based payment program?

( ) Yes (●) No

23b. ***If YES***, please indicate what type of value-based payment program model you predominately participate in by selecting from the list below:

Select type of value-based payment program model

23c. ***If either ACO model was selected from the list above***, please indicate which ACO you predominately participate with by select from the list below:

Select ACO

23d. If You selected "Other" to Question 23c. Please specify:

---

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), please answer Q.25, otherwise:
☑ check this box and skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel, sometimes called direct, concierge, or retainer-based practice?

Yes No

26. Workers' Compensation

Workers' Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- (•) Not Applicable (Do not complete below)
- ( ) I do not practice in Maryland.
- ( ) I do not employ anyone in my practice in Maryland.
- ( ) I employ one or more persons in my Maryland practice and have the following Workers' Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company
Policy Number
Expiration Date Enter as MM/DD/YYYY

DHMH is interested in learning the extent to which physicians are performing sterile compounding at their practice locations.

Compounding is the preparation of a medication that is not commercially available in the strength, concentration, or form needed for a specific patient. As defined by the Federal Drug Quality and Security Act, the term 'compounding' does not include "mixing, reconstituting, or other such acts that are performed in accordance with directions contained in approved labeling provided by the product's manufacturer and other manufacturer directions consistent with that labeling". Sterile compounding is the manipulation of a sterile or nonsterile product intended to produce a sterile final product, such as intravenous, epidural, and intraocular medications.

26a. Does your practice of medicine involve use of sterile compounded products?

( ) Yes (•) No

26b. If Yes, is sterile compounding being performed at your practice location?

( ) Yes (•) No

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in
Question 18 - Primary Practice / Office Location Primary Practice / Office Location

Please complete the following HIT questions for: **Whole Women's Health**

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?

(•) Yes ( ) No

b. To send prescriptions electronically to a pharmacy?

( ) Yes (•) No

If you answered Yes to 1b, what percentage of prescriptions are submitted electronically? [ ] %
(Enter whole number)

c. To generate reminders for you about preventive services needed for your patients?

( ) Yes (•) No

d. To access patient notes, medication lists, or problem lists?

( ) Yes (•) No

e. For clinical data and image exchanges with other physicians?

( ) Yes (•) No

f. For clinical data and image exchanges with hospitals and laboratories?

( ) Yes (•) No

g. To communicate about clinical issues with patients by email?

( ) Yes (•) No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

( ) Yes (•) No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

( ) Yes, all electronic ( ) Yes, part paper and part electronic (•) No ( ) Don't know

2a. If Yes, what is the name and version of the EHR system?

[Select EHR System ▼]

Other [ ]

2b. If **No**, please indicate your most significant reason for not using electronic medical records.

( ) Capital cost outlays ( ) Lack of technology standards ( ) Retiring soon
( ) Overburdened staff ( ) Intangible benefits (•) Not my decision
( ) Risk of privacy breaches

3. Have you used telemedicine for any purpose in the last 12 months?

( ) Yes (•) No

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 0
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?

- [ ] Second opinion
- [ ] Diagnosis
- [ ] Follow up
- [ ] Emergency
- [ ] Chronic disease management
- [ ] Other (specify) [ ]

The following questions are to be answered ONLY if your Practice Setting is one of the following:
(1) Solo; (2) Single-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff

4. Does your practice use high speed Internet?

○ Yes ◉ No

4a. If Yes, select your internet provider from the list below. ▼ *Please Specify :*

5. How do you access the Internet?

○ DSL ○ Cable Modem ○ Fiber to the office ○ Wireless ○ Other ◉ Unknown

6. Do you provide Wi-Fi access to your patients in your waiting area?

○ Yes ○ No ◉ Unknown

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

Chemical Biological Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 9/30/2015.

29. Please provide your electronic signature (type your name) below:

Name sacheen nathan

Today's Date 7/23/2015

Last four digits of Social Security Number: [redacted]

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

[redacted]

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started 7/23/2015

Date Application Submitted 7/23/2015

[redacted]