

Pre-medical School

Facility: Union College Degree: BS From 9/191 To 6/195
Street: 807 Union Street City: Schenectady State: NY
Facility: _____ Degree: _____ From / / To / /
Street: _____ City: _____ State: _____

Medical School

Facility: Albany Medical College Degree: MD From 9/195 To 5/199
Street: 97 New Scotland Ave City: Albany State: NY
Facility: _____ Degree: _____ From / / To / /
Street: _____ City: _____ State: _____

Date of medical school graduation: 6 / 14 / 99.

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	<u> / / </u>	<u> / / </u>
Street: _____	City: _____	State: _____	

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		<u>From</u>	<u>To</u>
Facility:	<u>Metropolitan Hospital</u>	<u>7/1/99</u>	<u>6/30/01</u>
Street:	<u>1901 1st Avenue</u>	State: <u>NY</u>	
	City: <u>NY</u>		

Facility:	<u>Westchester Medical Center</u>	<u>7/1/01</u>	<u>6/30/03</u>
Street:	<u>Gasslands Ave.</u>	State: <u>NY</u>	
	City: <u>Valhalla</u>		

Facility:	_____	Position: _____	<u> / /</u>	<u> / /</u>
Street:	_____	City: _____	State: _____	

Facility:	_____	Position: _____	<u> / /</u>	<u> / /</u>
Street:	_____	City: _____	State: _____	

- List other states (abbreviations) where you are currently or have ever been licensed: _____
- Are you certified by the American Board of Medical Specialties? Yes No
- List Board Certification(s): _____ Certification date: / /
 _____ Certification date: / /
- Have you attached an up-to-date copy of your curriculum vitae? Yes No
- Reason for requesting a Massachusetts medical license: Employment

- Name of Facility: Boston Medical Center
- Address: 91 E Concord St FL 3 City: Boston Mass
- Anticipated starting date in Massachusetts: 7 / / 03

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

Signature of Applicant [Handwritten Signature]

Date 1/21/02

SUPPLEMENT FORM

PRINT NAME: Sacheen Carr Ellis DATE: 1/21/03

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.


QUESTIONS

YES NO

1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?
2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?
- 6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?
- 6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?
- 8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
- 8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?

Applicant's Signature:  Date: 1/21/03

- 9-A. Have you ever voluntarily relinquished any medical staff membership?
- 9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
- 9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
- 9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
- 10. Have you ever been charged with any criminal offense, other than a minor traffic offense?
- 11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
- 12. Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?
- 13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?
- 14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?
- 15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
- 15-B. In the past ten (10) years, 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 has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature:  **Date:** 1/21/03

Sacheen Carr-Ellis

EDUCATION

Residence in Obstetrics and Gynecology, New York Medical College,
1999-Present, Co-Executive Chief, July 2002
Doctorate in Medicine, Albany Medical College, 1995-1999
Bachelor of Science, Union College, 1991-1995
Regents Diploma, Bronx High School of Science, 1991

EMPLOYMENT

1995-Present *Resident in Obstetrics and Gynecology, New York Medical
College/Metropolitan Hospital*

Provide medical and pre-natal care to female patients. Manage and instruct
junior residents in the field of obstetrics and gynecology. Present written and
oral case reviews to student and faculty members of the Department of
Obstetrics and Gynecology.

1995 *Executive Assistant, Communications Department, Environment One
Corporation*

News Letter Co-editor. Assisted in organizing company fund raising activities.

1991-1993 *Administrative Assistant, Harlem Hospital Department of Public
Health*

Assisted in the management of the Public Health Department office.

PRESENTATIONS

- Female Sexual Function
- Adolescent Pregnancy and Abstinence Only Education

RESEARCH

- The Effect of Anesthetic Inhalation Agents on Blood Loss During
Dilatation and Curettage Procedure

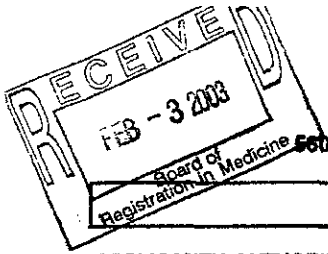
LANGUAGES

- English
- Spanish

AWARDS

Dr. George C. Carter Award
Significant Contribution to the Growth and Development of the Minority
Affairs Office at Albany Medical College.

216743



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

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Sacheen Carr Ellis Date: 1/20/03
Print or Type Name: Sacheen Carr Ellis
Name of Institution: New York Medical College

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: New York Medical College at Westchester Medical Center
If name of institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Sacheen Carr Ellis, MD participated in the following program:
(Print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO		
Residency	PGY 4	OB/GYN	7/99	6/03	Yes	ACGME

(Continued on page 2)

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APPLICANT'S NAME: Sachzen Carr Ellis

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?
6. During the applicant's participation, our postgraduate medical training was accredited by: ACGME Other: _____

COMMENTS: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the this for public). NO SEAL i, ry

Program Director's Signature: Sari Kaminsky
 Print Name: Sari J. Kaminsky, M.D.
Obstetrics & Gynecology
 Academic Title: Professor of Clinical Ob Gyn
 Telephone: (212) 423-6796 Today's Date: 1/28/03

PLEASE ACROSS

RETURNED FORM TO THE APPLICANT IN A SEALED ENVELOPE WITH YOUR SIGNATURE



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

Physician Name: Sacheen Carr Ellis, M.D.

License No.: 216743

Current Status: Active

License Expiration Date: 4/2/2010

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 85 E. Concord St.
6th floor
Boston
Massachusetts - 02118
United States of America

Home Address:

Business Address: 850 Harrison Avenue
YACC 4th Floor
Boston
Massachusetts - 02118
United States of America
(617) 414-5167

3) Email Address:

4) Fax Number: (617) 414-7300

5) Specialties
Obstetrics and Gynecology

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
New York

9) States where you were previously licensed
None Reported

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
Boston Medical Center	Boston



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sacheen Carr Ellis, M.D.

License No.: 216743

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	06/30/2009	06/30/2010	Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

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

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

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

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



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

Physician Name: Sacheen Carr Ellis, M.D.

License No.: 216743

22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes

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

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



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

Physician Name: Sacheen Carr Ellis, M.D.

License No.: 216743

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a 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.

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

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

Current Status: Active

License Expiration Date: 4/2/2012

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 85 E. Concord St.
6th floor
Boston
Massachusetts - 02118
United States of America

Home Address:

Business Address: 850 Harrison Avenue
YACC 4th Floor
Boston
Massachusetts - 02118
United States of America
(617) 414-5184

3) Email Address:

4) Fax Number: (617) 414-7300

5) Specialties
Obstetrics and Gynecology

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
New York

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
Boston Medical Center	Boston Boston



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	06/30/2011	06/30/2012	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?



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

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

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a 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.

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

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

Current Status: Active

License Expiration Date: 4/2/2014

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 210 Lincoln Street
Unit 503
Boston
Massachusetts - 02111
United States of America

Home Address:

Business Address: 850 Harrison Avenue
YACC 4th Floor
Boston
Massachusetts - 02118
United States of America
(617) 414-5184

3) Email Address:

4) Fax Number: (617) 414-7300

5) Specialties
Obstetrics and Gynecology

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

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

7) Drug License Numbers

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

9) States where you were previously licensed
New York

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
Boston Medical Center	Boston
Four Women Health Services	attleboro



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Boston Medical Insurance Co.	07/01/2013	07/01/2014	Claims made with tail coverage

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

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

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

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

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

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



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

Physician Name: Sacheen Nathan, M.D.

License No.: 216743

Compliance with Legal Responsibilities

Online profile:

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

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a 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.

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

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



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.: 216743 Renewal Date: 04/02/2004

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

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

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

Please make corrections (print)

- A) Mailing/Business Address:
3. Sacheen Carr Ellis

<input type="checkbox"/> Other Name(s)	<input type="checkbox"/> Name Change (enter name below)
Mailing Address: <u>85 East Concord St. 6th Floor</u>	
City/Town: <u>Boston</u>	State: <u>MA</u>
Zip: <u>02116</u>	Country: <u>U.S.</u>
Business Address: <u>Same as above</u>	
City/Town: _____	State: _____
Zip: _____	Country: _____
Business Telephone: (____) _____	
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.	

B) Home Address:

MAR - 1 2004

Home Phone:

Business Phone: (718)601-9693

4. a) Date of Birth: _____ b) Sex: F
c) SS#: _____
5. a) Name of Medical School: Albany Medical College of Union University
b) Year Graduated: 1999 c) Degree: M.D.

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

Code: _____ Code: _____

8. Drug License Numbers, if any:

- a) Federal (DEA): _____
b) Massachusetts: _____

6. Specialty Code(s) (See Table 1)
- | Code(s) | Hours per Week in Mass. |
|---------|-------------------------|
| OBG | 0 50 |
| | 0 |

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

NY _____

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

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

Facility Code: 5301 (AP) 100 % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %

If 999, print name(s): _____

PRINT YOUR LAST NAME: Carr-Ellis LICENSE NUMBER: 216743

11. My medical malpractice insurance is covered by Insurance Carrier Letter of Credit
Insurer's name. (Required): Boston Medical Center Ins. Co. Policy dates: From: 06/30/03 To: 06/30/04

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 0 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 25 hrs/wk B) outpatient care 25 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: [Handwritten Signature] Date: 2/20/2004

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: **Sacheen Carr Ellis**

License No.: **216743**

PART A

1) Current Status: **Active**

Renewal Due Date: **03/05/2006**

Birth Date: _____

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

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

85 East Concord Street
6th Floor
Boston, MA 02116

Check here to change this address

2b) HOME ADDRESS

Phone: _____

Check here to change this address

2c) BUSINESS ADDRESS

85 East Concord St.
6th Floor
Boston, MA 02116

Phone: (718)601-9693

Check here to change this address

RECEIVED
JAN 04 2006
Board of Registration
in Medicine

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

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

Home address cannot be a Post Office Box

Business Address: 850 Harrison Ave 4th floor
City/Town: Boston State: MA
Zip: 02118 Country: USA
Business Telephone: (617) 414-4893

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617 414-7300

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

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

List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.			
Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
Written OB/GYN Boards, currently Board eligible.				
OB/GYN Boards		to be taken in 2006	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

13 50/50/10

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis**

License No.: **216743**

01/05/06 8:31

<p>(See Renewal Instructions, page 4.)</p> <p>7) Drug License Numbers, if any:</p> <p>a) Massachusetts: _____</p> <p>b) Federal (DEA): _____</p> <p>c) Federal (DEA) XS: _____</p>	<p style="text-align: center;"><i>Please make corrections as necessary</i></p> <p>8a) Other states where you are <u>now</u> licensed to practice (Abbr.)</p> <p style="text-align: center;">NY _____</p> <p>8b) States where you were <u>previously</u> licensed (Abbr.)</p> <p style="text-align: center;">_____</p>
---	---

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

Principal Work Setting: Hospital Change to: _____

Please enter the approximate number of work hours at your principal work setting: 50

7

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

No Affiliations

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

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		Approximate # Hours per Week
		Current	Change	
Boston Medical Center	<input type="checkbox"/>	<u>Active</u>		<u>50</u>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 25 hrs/wk Change to: _____ hrs/wk

b) outpatient care 25 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: Boston Medical Ctr Ins. Change to: _____

Policy dates: From 06/30/05 To 06/30/06
(required)

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

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

Check one:

Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt (Please explain): _____

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis**

License No.: **216743**

13) Do you perform any surgery in your office? <i>(See Renewal Instructions, page 5.)</i> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. <i>(See Renewal Instructions, page 8.)</i> c) If you are exempt from CME requirements, check reason for exemption. <i>(See Renewal Instructions, page 8.)</i> CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training
--

01/25/2010 9:30

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis

License No.: 216743

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: _____



Date: 12 / 21 / 2008

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: **Sacheen Carr Ellis**

License No.: **216743**

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:

1	0	3	3	1	9	2	4	7	1
---	---	---	---	---	---	---	---	---	---
- I have personally applied for an NPI.
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	<u>Taxonomy (Specialty) Code</u>	<u>Taxonomy Description (Print)</u>										
Primary Provider Taxonomy:	<table border="1" style="display: inline-table;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											
Provider Taxonomy:	<table border="1" style="display: inline-table;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											
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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): _____ Country of Birth (if outside the US): _____

Gender: Male Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature:  Date: 12 / 21 / 2005

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

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis**

License No.: **216743**

PART A

1) Current Status: **Active** **Renewal Due Date: 03/05/2006** **Birth Date:**
 If you want to change your current status, please check one of the following boxes to indicate your new status:
 (Check only one). (See Renewal Instructions, page 3.)
 Active Retiring Inactive Do not wish to renew

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

2a) MAILING ADDRESS

85 East Concord Street
 6th Floor
 Boston, MA 02116

Check here to change this address

Please make corrections (print)

RECEIVED
JAN 04 2006
 Board of Registration in Medicine

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

2b) HOME ADDRESS

Phone: _____

Check here to change this address

RECEIVED
JAN 23 2006
 Board of Registration in Medicine

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

85 East Concord St.
 6th Floor
 Boston, MA 02116

Phone: (718)601-9693

Check here to change this address

Business Address: **850 Harrison Ave 4th floor**
 City/Town: **Boston** State: **MA**
 Zip: **02118** Country: **USA**
 Business Telephone: **(617) 414-4893**

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: **617 414-7300**

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

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

Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
Written OB/GYN Boards		currently Board eligible	<input type="checkbox"/>	<input type="checkbox"/>
OB/GYN Boards		to be taken in 2006	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

03/2004/008-951

48

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis**

License No.: **216743**

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers, if any:</p> <p>a) Massachusetts:</p> <p>b) Federal (DEA):</p> <p>c) Federal (DEA) XS:</p>	<p><i>Please make corrections as necessary</i></p> <p>8a) Other states where you are <u>now</u> licensed to practice (Abbr.)</p> <p style="text-align: center;"><u>NY</u> _____</p> <p>8b) States where you were <u>previously</u> licensed (Abbr.)</p> <p>_____</p>
--	--

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

Principal Work Setting: Hospital Change to: _____

Please enter the approximate number of work hours at your principal work setting: 50

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

No Affiliations Please enter the approximate number of work hours for each Health Care Facility below:

Health Care Facility <i>(See Renewal Instructions, page 4.)</i>	Delete?	Staff Category		Approximate # Hours per Week
		Current	Change	
Boston Medical Center	<input type="checkbox"/>	<u>Active</u>		<u>50</u>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 25 hrs/wk Change to: _____ hrs/wk

b) outpatient care 25 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: Boston Medical Ctr Ins. Change to: _____

Policy dates: From 06/30/05 To 06/30/06
(required)

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

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

Check one:

Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis**

License No.: **216743**

13) Do you perform any surgery in your office? <i>(See Renewal Instructions, page 5.)</i> 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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. <i>(See Renewal Instructions, page 8.)</i> c) If you are exempt from CME requirements, check reason for exemption. <i>(See Renewal Instructions, page 8.)</i> CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training
--

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis

License No.: 216743

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: _____

Date: 12 / 21 / 2008

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: **Sacheen Carr Ellis**

License No.: **216743**

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:

1	0	3	3	1	9	2	4	7	1
---	---	---	---	---	---	---	---	---	---
- I have personally applied for an NPI.
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	<u>Taxonomy (Specialty) Code</u>	<u>Taxonomy Description (Print)</u>										
Primary Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr></table>											

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

Gender: Male Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature:  Date: 12 / 21 / 2005

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

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis, M.D.**

License No.: **216743**

01/29/08 97 18

PART A

1) Current Status: Active **Renewal Due Date:** 03/05/2008 **Birth Date:**

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

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

850 Harrison Avenue
 4th Floor
 Boston, MA 02118

Check here to change this address

Mailing Address: 85 E. Concord St.
 City/Town: BOSTON State: MA
 Zip: 02118 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

850 Harrison Avenue
 4th Floor
 Boston, MA 02118

Phone: (617)414-4893

Check here to change this address

RECEIVED
JAN 28 2008
 Board of Registration
 in Medicine

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) 414-7300

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis, M.D.**

License No.: **216743**

01/29/08 51 19

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers Corrections:</p> <p>a) Massachusetts: _____</p> <p>b) Federal (DEA): _____</p> <p>c) Federal (DEA) XS: _____</p>	<p style="text-align: center;"><i>Please make corrections as necessary</i></p> <p>8) Other states where you are <u>now</u> licensed to practice</p> <p style="text-align: center;"><u>NY</u> _____</p> <p>9) States where you were <u>previously</u> licensed</p> <p>_____</p>
--	--

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 <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
Boston Medical Center	BOSTON	MA	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 25 hrs/wk Change to: _____ hrs/wk

b) outpatient care 25 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: Boston Medical Ctr Ins. Change to: _____

Policy dates: From 06/30/07 To 06/30/08

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

Check one: Not involved with direct or indirect patient care in Massachusetts

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

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

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

Massachusetts Physician Renewal Application

Physician Name: **Sacheen Carr Ellis, M.D.**

License No.: **216743**

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

<p>14) CLAIMS MADE</p> <p>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).</p> <p>b) PENDING: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been finally settled or finally adjudicated?</p>	
<p>15) CLAIMS CLOSED</p> <p>Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?</p>	
<p>16) OTHER CIVIL LAWSUITS</p> <p>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.</p> <p>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?</p> <p>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?</p>	
<p>17) CRIMINAL CHARGES</p> <p>a) Have you been charged with any criminal offense during this time period?</p> <p>b) Have any criminal offenses/charges against you been resolved during this time period?</p> <p>c) Are there any criminal charges pending against you today?</p> <p>d) Are any Applications for Issuance of Process pending against you?</p>	
<p>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS</p> <p>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</p> <p>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?</p> <p>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?</p> <p>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?</p>	
<p>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?</p>	
<p>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?</p>	
<p>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?</p>	

<p>22) CME CERTIFICATION:</p> <p>a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A CME waiver request form must be submitted at least 30 days prior to your license expiration date.</p> <p>c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)</p> <p style="text-align: center;">CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training</p>

01/29/08 91 21

Massachusetts Physician Renewal Application

Physician Name: Sacheen Carr Ellis, M.D.

License No.: 216743

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: _____



Date: 1/23/2008

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

01/23/08 01 23