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

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| 74712 | ACTIVE | $250.00 | 01/19/96 | $25.00 |

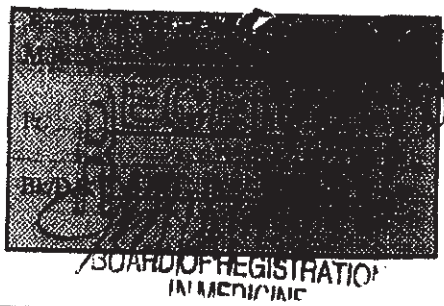
Mailing Address:
JAMES ADAM GREENBERG, M.D.

**Correction of Mailing Address**

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

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

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




**Pre-Printed Information**

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

2. Business Address:
   33 POND AVENUE
   BROOKLINE, MA 02146

3. Date of Birth: Sex: M
   Lic. Issue Date: 07/24/91 SS#:

   Home Phone ( ) - Business Phone ( ) -

4. Name of Medical School:
   New York University School of Medicine
   Year Graduated: 88 Degree: MD

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

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

| Code | Hours per Week in Mass. | |
|---|---|---|
| OBG | 80 | Obstetrics and Gynecology |

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

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

**Corrections of Pre-Printed Information**

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

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

Home: _____ Business: (617) 232-7010

Full Name of Medical School: _____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code _____ Hours per Week in Mass. _____
_____ _____
If OS, print specialty: _____

Code: OG Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

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

PRINT NAME AND NUMBER: Physician Last Name: Greenberg Registration Number: 24712

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

Facility Code: 921 / ✓ (AP) Facility Code: 059 / ✓ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 168 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

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

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

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

List Insurer: CRICO

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

State hours: ___ Basis for exempt: ___

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

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

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 30 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 10 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 10 %

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

**IN THE PAST TWO YEARS:**

| | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? | | |
| 19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? | | |
| 20. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? | | |
| 22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine? | | |
| 23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice? | | |
| 24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? | | |
| 25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested ___ No, training program exemption (see instruction booklet). ___ | | |

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

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

Signature: J E Greenberg, MD Date: 12/4/95

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

# Physician Registration Renewal Application

RECEIVED
DEC 18 2001
Board of Registration in Medicine

REDACTED COPY

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

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

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

1. Current Status: Active Registration No.: 74712 Renewal Date: 01/19/2002

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

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

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

3. A) Mailing/Business Address:
JAMES ADAM GREENBERG
1153 Centre Street
Boston, MA 02493

B) Home Address:

Home Phone:

Business Phone:

**Please make corrections** (type or print)

Other Name(s): _____

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

Business Address: _____
City/Town: _____ State: _____
Zip: 02130 Country: _____
Business Telephone: (617) 983-7003

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

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

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

c) SS#:

5. a) Name of Medical School:
New York University School of Medicine
b) Year Graduated: 1988 c) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| | 0 | |

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

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

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

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

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

Facility Code: 921/✓ (AP) 75 % Facility Code: 168/ (AP) % Facility Code: / (AP) %
Facility Code: 048/✓ (AP) 25 % Facility Code: / (AP) % Facility Code: / (AP) %
If 999, print name(s): _____

PRINT YOUR LAST NAME: Greenberg LICENSE NUMBER: 74712

11. My medical malpractice insurance is covered by a) ☑ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: CRICO Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☑ No
13. A. What is your principal work setting? (See Table 4) 2 0
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 30 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 10 %

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

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

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

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

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

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

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

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

Signature: J. Greenberg, MD Date: 12/15/01

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

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

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

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

# Physician Registration Renewal Application

**Before proceeding, please read the instruction booklet.**
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

RECEIVED
NOV 24 1999
Registration

Registration No.: 74712 Renewal Date: 01/19/2000 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
JAMES ADAM GREENBERG

B) Home Address:

Home Phone:
Business Phone:

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

5. A) Name of Medical School:
New York University School of Medicine

B) Year Graduated: 1988 C) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| | 0 | |

**Please make corrections** (type or print)

Other Name(s): _____

Mailing Address: 1153 Centre Street #36
City/Town: Boston State: MA
Zip: 02493 Country: _____

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

Home: (___) _____
Business: (617) 983-7003

Date of Birth: (M/D/Y): __/__/__ Sex: ☐ M ☐ F
SS#: ___-___-____

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

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

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

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

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

**PRINT NAME AND NUMBER:** Last Name: Greenberg Registration Number: 74712

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

Facility Code: 921/✓ (AP) 50 % Facility Code: 168/✓ (AP) 0 % Facility Code: ___/___ (AP) ___ %

Facility Code: 048/✓ (AP) 50 % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %

If 999, print name(s): _____

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

Name of Insurer: CRICO Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 30 %

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

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

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

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

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

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

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

Signature: [signature], MD Date: 11/21/99

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

# Commonwealth of Massachusetts Board of Registration in Medicine
## Ten West Street, 3rd Floor, Boston, Massachusetts 02111
## 1993-1995 Physician Registration Renewal Application

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| [illegible] | ACTIVE | $250.00 | 01/19/94 | $25.00 |

**Mailing Address:**

[illegible] ADAM GREEN JR., M.D.

**Correction of Mailing Address:**

Address (Mailing): _____

City/Town: _____

State: _____

Country Code (See Table 1): 0

**Directions:** **Staple check to bottom of form. Add late fee if necessary.**

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

**For Office Use Only**

M.R. DEC 15 1993 fp

Pr. DEC 15 1993

Bk/D.E. _____

**Pre-Printed Information**

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

2. a) Address (Home):

   b) Address (Business):

   [illegible] WOMEN'S HOSPIT
   [illegible] FRANCIS STREET
   [illegible] BOSTON MA 02115

3. Date of Birth: Sex: M
   Lic. Issue Date: 07/24/91 SS#:
   Telephone Number:
   Home Business
   ( ) -

4. Name of Medical School:
   New York University School of Medicine
   Year Graduated: 83 Degree: MD

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

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

| Code | Hours per Week in Mass. |
|---|---|
| [illegible] | [illegible] Obstetrics and Gynecology |

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

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

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

**Corrections of Pre-Printed Information**

Name: _____

Address (Home): _____

City/Town: _____

State: _____ Zip: _____

Country Code: _____ If 999 print Country: _____

Address (Business): 33 Pond Avenue

City/Town: Brookline

Country Code: 0 If 999 print Country: _____

Date of Birth (M/D/Y): / / Sex (M/F): _____

Lic. Issue Date (M/D/Y): / / SS#: _____

Telephone Number:

Home: ( ) Business: ( )

Full Name of Medical School: _____

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

| Code | Hours per Week in Mass. |
|---|---|
| | |
| | |

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

Federal (DEA): _____

State (MA): _____

**Staple Check Here**

EM

PRINT NAME AND NUMBER: Physician Last Name: Greenberg Registration Number: 74712

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

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

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

List Insurer: CRICO

*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___

(State how otherwise exempt): ___

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 921 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: 168 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 20

b) Care of patients in Massachusetts (MA) (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in MA? 20 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 40 hrs/wk in MA

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

**IN THE PAST TWO YEARS:**

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

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

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

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

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

Signature: [signature] MD Date: 11/18/03

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

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 24712 | ACTIVE | $150 | 01/19/92 |

Dr. JAMES ADAM GREENBERG

**For Office Use Only**

M.R. ___ / ___ /
Pr. Kelly 2/19/92
Bk. ___ / ___ /
Ch. ENTERED ___ / ___ /
D.E. ___ / ___ /

RECEIVED FEB 19 92

**Directions:**

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

**Activity Status:**

I am applying to be registered with the following status: Active ✓ Inactive ___

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

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

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

Name: ___

2. a) Address (Home):

Address: ___
City/Town: ___
State: ___
Country Code: ___ (If 999 write Country): ___

2. b) Address (Business): ~~45~~ Brigham & Women's Hospital
45 Francis Street
Boston, MA 02115

Address: Brigham & Women's Hospital 45 Francis Street
City/Town: Boston
State: MA Zip: 02115
Country Code: 0 (if 999, write Country): ___

3. Date of Birth: ___ Sex: M
Lic. Issue Date: 07/24/91 SSN #
Telephone Number:
Home ( ) - Business ( ) -

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

4. Medical School Code NY019 Year Graduated 88 Degree: MD
Name of School:
New York University School of Medicine

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

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

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

| Code | Hours per Week in Mass. |
|---|---|
| 0 | |
| 0 | |

| Code | Hours per Week in Mass. |
|---|---|
| OBG | 80 |
| | |

If OS, write specialty: ___

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

Code: ___
Code: ___

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

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

30M - 9/90 - P813971

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

FILL IN NAME AND NUMBER:

Physician Last Name: Greenberg Registration No.: 74712

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

List Insurer: CRICO

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

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

*(State how otherwise exempt)*: _____

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

Facility Code: 921 / (AP) Facility Code: ___ / (AP) Facility Code: ___ / (AP)

Facility Code: 168 / (AP) Facility Code: ___ / (AP) Facility Code: ___ / (AP)

*If 999, write* Name(s): _____

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

Facility Code: 069 Facility Code: ___ Facility Code: ___ Facility Code: ___

*If 999, write* Name(s): _____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

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

b) If you are in a MA program, are you a i) Resident ✓ ii) Clinical Fellow ___ or iii) Research Fellow ___? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program? 80 hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 40 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 80 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 10

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

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

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

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

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

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

Signature: _____ Date 2/5/92

FED. OK Batch # 323

Date 2/19/91 By FP

0319

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Application for Endorsement Registration - NATIONAL BOARDS
(Fee $150.00 must accompany APPLICATION - No currency)

Approved
Disapproved:

Filed:
By:
Form of Fee:

FOR OFFICE USE

Certificate # 74712 Application #
Date of Issue: 7/24/91

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name James (First) Adam (Middle) Greenberg (Last)

Date of Birth

Place of Birth New York City, NY

Name on Birth Certificate same

Mailing Address:*

Address valid from (dates) present

Phone # DAY: HOME:

**Pre-medical Education**

School Amherst College, Amherst, MA

Dates Attended 9/80 - 5/84

**Medical Education**

School New York University School of Medicin

Dates Attended 8/84 - 6/88 NY 019

**POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS**

| Place | Position | Dates |
|---|---|---|
| Brigham & Women's Hospital | Resident | 6/88 - present |

List all states where you are or have been licensed:

Are you a Diplomate of a Specialty Board?
(name, if applicable)

REASON APPLYING FOR MASS. LICENSE: I intend to practice in Massachusetts

*NOTE: Change of address must be submitted IN WRITING to the Board of Registration in Medicine. Please include effective dates for new address upon submitting this information.

POST GRADUATE EDUCATION AND HOSPITAL APPOINTMENTS:
Chronologically list all educational and professional training and experience from the date of graduation from medical school to the present. Account for all periods of time whether or not engaged in the practice of medicine.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION
FOR FULL LICENSE

FOR OFFICE USE ONLY
Full License Application___
Pending___ Approved___
License #

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: James Adam Greenberg
Mailing ADDRESS:

Day phone:

Valid from: 5/91

Permanent address (if different from mailing address):

**YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.**

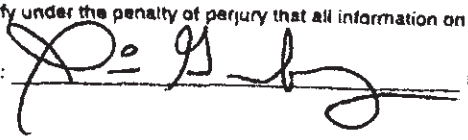
| | YES | NO |
|---|---|---|
| 1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete FORM 1B, attached, for EACH claim) | | |
| 2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? | | |
| 3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name? | | |
| 4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college? | | |
| 5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners? | | |
| 6. Have you ever failed a foreign licensing or certification examination? | | |
| 7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason? | | |
| 8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? | | |
| 9 Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 10. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached. | | |
| 11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason? | | |
| 12. Have you ever, for any reason, lost American Specialty Board Certification? | | |
| 13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? | | |
| 14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? | | |
| 15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time? | | |
| 16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 18. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. | | |

**NOTE ON QUESTIONS 16-18:** The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #19 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Temporary Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE:  DATE: 6-7-91

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

# Physician Registration Renewal Application

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

RECEIVED
NOV 25 1997
BOARD OF REGISTRATION IN MEDICINE

Registration No.: 74712 Renewal Date: 01/19/98

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

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

3. A) Mailing/Home Address:

JAMES ADAM GREENBERG, M.D.

B) Business Address:
33 POND AVE
BROOKLINE, MA 02146-7128

Home Phone:
Business Phone: (617)232-7010

4. A) Date of Birth:
B) Lic. Issue Date: 07/24/91
C) Sex: M
D) SS#:

5. A) Name of Medical School:
New York University School of Medicine
B) Year Graduated: 88 C) Degree: MD

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 80 | Obstetrics and Gynecology |

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

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

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

**Corrections** (type or print)

Other Name(s): _____

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

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

Home: ( )
Business: ( ) _____

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

Full Name of Medical School: _____

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

Code(s) Hours Per Week in Mass.
_____ _____
_____ _____
If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: _____

Abbr: _____

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

**PRINT NAME AND NUMBER:** Last Name: Greenberg Registration Number: 74712

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

Facility Code: 921 ✓(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
Facility Code: 168 ✓(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
If 999, print name(s): _____

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

Facility Code: 069 Facility Code: 059 Facility Code:____ Facility Code:____ Facility Code:____
If 999, write Name(s): _____

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

Name of Insurer: CRICO

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

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

Please explain exemption: _____

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

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

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

1) Average weekly hours involved in: a) outpatient care 32 hrs/wk b) inpatient care 30 hrs/wk

2) *What is the approximate percentage of your patient care hours in primary care ?* 15 %

# PART A

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

## IN THE PAST TWO (2) YEARS:

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

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

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

Signature J. Greenberg, MD Date: 11/24/97

## I. PHYSICIAN INFORMATION

JAMES ADAM — *First Name* — *Middle Initial*
GREENBERG — *Last Name* — *Suffix*

*Make changes to name here*

Mass License # 74712
License Status Active

First Issue Date 07/24/91

33 Pond Ave.
Brookline, MA 02146-7128
U.S.A.
(617) 232-7010

Hospital Affiliation

Brigham & Women's Hospital
Massachusetts General Hospital
New England Baptist Hospital

*Make address corrections here:*

*Make any corrections to above here:*

Insurance Plan Affiliation:

Licenses Held in Other States:

*(Please correct as necessary)*

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

## II. EDUCATION & TRAINING

New York University School of Medicine — *Medical School* — MD — *Degree* — 88 — *Date*

*Make corrections here*

*Residency Program(s)* — *Start* 1986 — *End* 1992 end

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

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

## III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

*Make any corrections here:*

## BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

*Make any corrections here:*

## IV. BOARD DISCIPLINE

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

| Nature | Date | Board Action |
|---|---|---|

## V. HOSPITAL DISCIPLINE

| Hospital | Date | Disciplinary Action |
|---|---|---|

## VI. CRIMINAL CONVICTIONS

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

.....

.....

## VII. MALPRACTICE

Details of claims paid for Dr. GREENBERG

No. of Years in Practice: # 8

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

## VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

| Awards, Honors | Publications |
|---|---|
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |
| ..... | ..... |

***Note: Please return the survey in the enclosed envelope to:***
Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

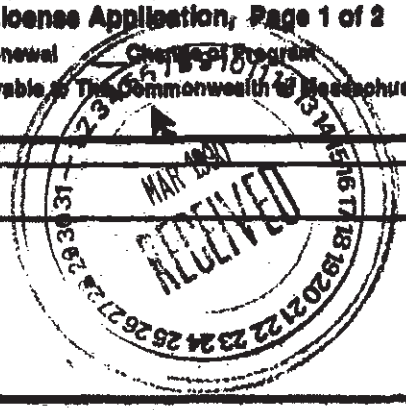
**Commonwealth of Massachusetts, Board of Registration in Medicine**

**Ten West Street, 3rd Floor, Boston, Massachusetts 02111**

**Limited License Application, Page 1 of 2**

___Renewal ___Change of Program

**Fifty Dollar Fee Payable to The Commonwealth of Massachusetts**




| Board Use Only: | | | |
|---|---|---|---|
| Registration No. | Status | Fee $50 | Date |

M.R. 72764 3/13/90
Pr. ___ ___
Bk. ___ ___
Oh. ___ ___
D.E. ___ ___
Fl. ___ ___

**Important:**

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--Even though the Board may have the information, it is not adequate to state that the Board already has the information.
- *Sign the application at the bottom of page two.*
- Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.

**SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)**

1. Name (LAST:) Greenberg (FIRST:) James (M.I.:) A
2. Mailing Address: ___
3. Name & Address of Training Hospital: Brigham & Women's Hospital
   75 Francis Street Boston, MA 02115
4. Current Limited License Number: 89-1110-92
5. Change of Program Applicant:

   List previous license numbers, Training Institutions and Programs involved:

   ___

   ___

   ___

5a. Was previous training a prerequisite for entering into this program ___Yes ___No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: ___Yes ___No Program Director's Certification has been requested: ___Yes ___No.

6. Renewal Applicant Only: To be completed by Program Director.
I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ___Yes _X_No.

Type or Print Name and Title Kenneth J. Ryan, M.D., Chairman, Department of Obstetrics and Gynecology

Signature of Program Director [signature] Program Director Date 2/28/90

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that James A. Greenberg, M.D. has been appointed to the position of Intern ___, Resident PGY-3,

Fellow ___ in Program Obstetrics & Gynecology (Program) at Brigham and Women's Hospital (Institution) beginning 7/1/90 and

Anticipated completion date of training 6/30/92.

This program is accredited by the ACGME: Yes X No ___
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___.

Designated Official's Signature: Sheridan Kassirer

Type or Print Name and Title: Sheridan Kassirer, Vice President Date 3/1/90

(Applicant See reverse side - You must complete Section C)

FORM 11/89

**SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)**

7. Other States where you are now fully licensed to practice:
(Abbreviate):_____

**Questions 8 through 14 not applicable.**

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

| | Yes | No |
|---|---|---|
| 15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you been a defendant in any criminal proceeding other than a minor traffic offense? | | |
| 17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college? | | |
| 24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)? | | |

**IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.**

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

**I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.**

**I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.**

**Applicant's Signature:** _____ **Date:** 2/5/90

FORM 11/89

649
03791
W2L
V $50

**Commonwealth of Massachusetts, Board of Registration in Medicine**

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

**Limited License Application, Page 1 of 2**

__Renewal

**Fifty Dollar Fee Payable to The Commonwealth of Massachusetts**

**Board Use Only:**

| Registration No. | Status | Fee $50 | Date |
|---|---|---|---|
| | | | |

M.R. ____ __/__/__
Pr. ____ __/__/__
Bk. ____ __/__/__
Ch. ____ __/__/__
D.E. ____ __/__/__
Fl. ____ __/__/__

**Important:**

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--Even though the Board may have the information, it is not adequate to state that the Board already has the information.
- *Sign the application at the bottom of page two.*
- Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.

**SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)**

1. Name (LAST:) Greenberg (FIRST:) James (M.I.:) A
2. Mailing Address: _____
3. Name & Address of Training Hospital: Brigham & Women's Hospital 75 Francis Street Boston, MA
4. Medical School Name: New York University Medical School
5. Current Limited License Number: 89-1110-92
6. To be completed by Program Director:

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes __X__No

Type or Print Name and Title Kenneth J. Ryan, M.D., Program Director

Signature of Program Director _____

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that James Greenberg, M.D. has been appointed to the position of Intern ____, Resident PGY-4, Fellow ____ in Program Obstetrics & Gynecology (Program) at Brigham & Women's Hospital (Institution) beginning July 1, 1991 and Anticipated completion date of training June 30, 1992.

This program is accredited by the ACGME: Yes X No
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___.

Designated Official's Signature: _____

Type or Print Name and Title: Hiroshi Tokubo, Assistant VP Medical Staff Services Date 3/19/91

(Applicant See reverse side - You must complete Section C)

FORM 1/91

**SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)**

7. Other States where you are now fully licensed to practice:
(Abbreviate):_____

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

| | Yes | No |
|---|---|---|
| 15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you been a defendant in any criminal proceeding other than a minor traffic offense? | | |
| 17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college? | | |
| 24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)? | | |

**IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.**

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

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

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature:_____ Date: 3/14/91

## Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

### Limited License Application, Page 1 of 2

**Change of Program**

**Fifty Dollar Fee Payable to The Commonwealth of Massachusetts**

**Board Use Only:**

| Registration No. | Status | Fee | Date |
|---|---|---|---|
| | | $50 | |

M.R. ____ ___/___/___
Pr. ____ ___/___/___
Bk. ____ ___/___/___
Ch. ____ ___/___/___
D.E. ____ ___/___/___
Fl. ____ ___/___/___

**Important:**

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

**SECTION A: Sworn Statement to be Completed by Applicant.** (Complete Reverse Side Also)

1. Name (LAST:)_____(FIRST:)_____(M.I.:)_____
2. Mailing Address:_____
3. Name & Address of Training Hospital:_____
4. Name of Medical School:_____Year Graduated_____Location:_____
5. Current Limited License Number:_____

List previous license numbers, Training Institutions and Programs Involved:

_____

_____

_____

5a. Was previous training a prerequisite for entering into this program _____Yes _____No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: _____Yes ____No Program Director's Certification has been requested: ____Yes ____No.

**6. To be completed by current Program Director:**
**I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated.** Has the physician been subject to past or pending disciplinary action in this program?_____Yes _____No.

Type or Print Name and Title_____

**Signature of Program Director**_____Date_____

**SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.**

This certifies that_____has been appointed to the position of Intern_____, Resident_____,

Fellow_____in Program_____(Program) at_____(Institution) beginning_____and

Anticipated completion date of training_____.

**This program is accredited by the ACGME: Yes___ No___**
**If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___.**

**Designated Official's Signature:**_____

Type or Print Name and Title: Hiroshi Tokubo, AVP Med Staff Svcs Date 3/19/91

(Applicant See reverse side - You must complete Section C)

**FORM 1/91**

**SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)**

7. Other States where you are now fully licensed to practice:
(Abbreviate):_____

**Questions 8 through 14 not applicable.**

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

| | Yes | No |
|---|---|---|
| **15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?** | | |
| **16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?** | | |
| **17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?** | | |
| **18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?** | | |
| **19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?** | | |
| **20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?** | | |
| **21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?** | | |
| **22. Are you now, or have you been in the past, dependent upon alcohol or drugs?** | | |
| **23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?** | | |
| **24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?** | | |

**IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.**

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

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

**I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.**

**I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.**

**Applicant's Signature:**_____ **Date:**____/____/____

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks) L 7902

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.

FOR OFFICE USE
Date Received 5/27/88
Certificate # _____
By: KHG Form of Fee: M.O.

PLEASE PRINT OR TYPE

SECTION A:

Name: James (First) Adam (Middle) Greenberg (Last)

Mailing Address: _____

Date of Birth: _____

Pre-medical School: Amherst College

Medical School: NYU School of Medicine

Date of Graduation (Yr.) 6-3-88

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? No
(give number, if applicable)

PLEASE ANSWER QUESTIONS 1-19 ON THE SUPPLEMENTTAL CHECKLIST

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that James A. Greenberg, M.D. has been appointed to the position of

1st Yr. Resident in Ob/Gyn in Brigham & Women's Hospital & Affiliates
(Name of Hospital)

beginning 20 June 1988 and ending 19 June 1989.

Is the purpose of this application participation in a training program yes (yes or no)
If yes, is this program ACGME or RRC accredited? yes (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? ___ (yes or no)

Sheridan Kassum — Vice President — 5/16/88
SIGNATURE — OFFICIAL CAPACITY — DATE

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

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

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

Date _____ 19 ____

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

From _____ To _____
Month Day Year Month Day Year

From _____ To _____
Month Day Year Month Day Year

School Seal

_____
Dean

_____
School

---

All Medical Graduates

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

Date May 18, 19 88

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| From | August | 29 | 1984 | To | May | 31 | 1985 |
| | Month | Day | Year | | Month | Day | Year |
| From | September | 9 | 1985 | To | May | 23 | 1986 |
| | Month | Day | Year | | Month | Day | Year |
| From | September | 8 | 1986 | To | July | 10 | 1987 |
| | Month | Day | Year | | Month | Day | Year |
| From | September | 28 | 1987 | To | *May | 27 | 1988 |
| | Month | Day | Year | | Month | Day | Year |
| From | | | | To | | | |
| | Month | Day | Year | | Month | Day | Year |

and has received the degree of Doctor of Medicine on *June 3, 19 88

from New York University School of Medicine
(name of Medical School)

School Seal

Saul J. Farber
signature of Dean

Saul J. Farber, M.D., M.A.C.P./Dean

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

*Is expected to complete requirments for graduation on May 27, 1988, and is expected to graduate on June 3, 1988.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
LIMITED LICENSE

FOR OFFICE USE ONLY
Limited License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: James Adam Greenberg
PERMANENT ADDRESS: _____

LOCAL MAILING: _____

ADDRESS IN (MA): _____

HOSPITAL: Brigham & Women's Hospital
ADDRESS: 75 Francis Street
Boston, MA 02115

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

| | YES | NO |
|---|---|---|
| 1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? | | |
| 2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill? | | |
| 3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name? | | |
| 4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college? | | |
| 5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners? | | |
| 6. Have you ever failed a foreign licensing or certification examination? | | |
| 7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason? | | |
| 8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action? | | |
| 9 Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 10. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached. | | |
| 11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason? | | |
| 12. Have you ever, for any reason, lost American Specialty Board Certification? | | |
| 13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____ | | |
| 14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? | | |
| 15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time? | | |
| 16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 18. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____. | | |

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #19 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Limited Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: _____ DATE: 5-19-88

89-1110-92

**Commonwealth of Massachusetts Board of Registration in Medicine**
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
**Limited License Application, Page 1 of 2**

Board Use Only: 29436

| Registration No. | Status | Fee | Date |
|---|---|---|---|
| | | $25 | |

M.R. ____ ____
Pr. ____ ____
Bk. Card 3/24/89
Ch. ____ ____
D.E. ____ ____
Fl. ____ ____

**Important:**
. *Read the accompanying instructions in their entirety before completing this form.*
. *Print legibly or type your answers.*
. *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
. *Sign the application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
. *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*

**Applicants please check one:** I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ____ 2) Graduate of Foreign Medical School ____ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program____.

This is a (check one) 1) New Application____ 2) Renewal____ If renewal, indicate current Limited License Number _____ 3) Change of Program____

**PLEASE NOTE:** GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

**Applicants please circle one:** I will be a PGY1 PGY2 PGY3 PGY4 PGY5 PGY6 PGY7 Other (Specify):_____

**SECTION A: Sworn Statement to be Completed by Applicant.** (Complete Reverse Side Also)

1. a) Name (LAST:) Greenberg (FIRST:) James (M.I.:) A

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation):
No

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: No

2. a) Current Address (Mailing) (Valid Until _____)

2. b) New Address (Mailing) (Valid After _____)

2. c) Address (Work/Hospital): Dept of OB/GYN Brigham & Women's Hosp
75 Francis St. Boston, MA 02146

2. d) Telephone (Work/Hospital): 617.732-6987 Extension page 2. e) Telephone (Home):

3. Date of Birth (MO/DA/YR): 1 [illegible] 5. Social Security No. (*Optional*):

4. Sex: MALE ✓ FEMALE___

6. a) Medical School Name: NMU

6. b) Year Graduated: 1988 6. c) Degree: M.D. ✓ D.O.___ Other (Specify)_____

6. d) Country: U.S. ✓ State___ Canada___ Province_____ If Other *write* Name:_____

7. Specialty: OB/GYN

8. Name of Pre-medical School(s): Amherst College

Location: (City, State, Country) Amherst, MA

9. Have you ever held a limited license in Massachusetts? Yes ✓ No___ If yes, list the license numbers you have held and name the institutions involved: Number of Massachusetts limited licenses: 1 Names of the institutions involved and the registration numbers:
Brigham & Women's # [illegible] 96237

RECEIVED MAR 1989

10. If you have had any one of the following, please circle which one and attach an explanation to this form: 1) A leave of absence from medical school 2) More than four years of medical school education. Question 10 applies to me: Yes___ No ✓ I have attached an explanation: Yes___ No ✓

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

**I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.**

**I hereby certify under the penalties of perjury that all information on this form--front and back and (#)____ attached pages--is true.**

Applicant's Signature: [signature] Date: 2/22/89

(See reverse side - You must complete Section C)

FORM 1/89

## Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

**SECTION B**: To be completed and signed by the Designated Official of the institution at which the Applicant has received an appointment.

This certifies that James A. Greenberg, M.D. has been appointed to the position of PGY 2 in

(Specialty) Obstetrics and Gynecology at Brigham and Women's Hospital and Affiliates

beginning 1 July 1989 and ending 30 June 1990.

This program is accredited by the ACGME: Yes X No___
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___ Anticipated completion date of training program:_____

Designated Official's Signature: Sheridan Kassirer

Type or Print Name and Title: Sheridan L. Kassirer, Vice President Date:_____

If renewal, I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes___ No___

Signature of Designated Official Sheridan Kassirer

Type or Print Name and Title: Sheridan Kassirer, V.P. Date:_____

**********

**SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)**

11. Other States where you are now licensed to practice (Abbreviate): —

12. *States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate):* —

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes___ No✓ I have attached an explanation: Yes___ No✓

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No✓ **If yes, please attach an explanation detailing your reasons for not completing the program(s).** In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes___ No✓ Program Director's Certification has been requested: Yes___ No___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

| | Yes | No |
|---|---|---|
| 15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you been a defendant in any criminal proceeding other than a minor traffic offense? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination, or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college? | | |
| 24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)? | | |

**********

FORM E

**Name of Training Institution:** Brigham and Women's Hospital

**Address:** 75 Francis St. , Boston, MA 02115

**BOARD OF REGISTRATION IN MEDICINE**
**TEN WEST STREET, THIRD FLOOR**
**BOSTON, MASSACHUSETTS 02111**

## VERIFICATION OF MEDICAL INSTRUCTION AND GRADUATION

**Instructions:**

**To the Applicant**: This Form E must be sent to your medical school for completion by the Dean or designated official and returned **DIRECTLY by the medical school to the Board's office address above.** If you attended more than one medical school, you must duplicate this form and forward a copy to each medical school at which your received academic credit.

**To the Medical School:** Please complete the enclosed form in full and return **it DIRECTLY to the address above.** This verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine at the above address. Thank you for your cooperation.

I HEREBY CERTIFY THAT James Greenberg HAS COMPLETED AND ATTENDED
(name of applicant) Previous limited license # 96237

FOR _____ ACADEMIC YEARS OF INSTRUCTION, OF NOT LESS THAN THIRTY TWO WEEKS IN
(number)

EACH ACADEMIC YEAR AT _____
(name and location of medical school)

(Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year):

FROM: _____ TO: _____
Month Day Year Month Day Year

FROM: _____ TO: _____
Month Day Year Month Day Year

FROM: _____ TO: _____
Month Day Year Month Day Year

FROM: _____ TO: _____
Month Day Year Month Day Year

FROM: _____ TO: _____
Month Day Year Month Day Year

FROM: _____ TO: _____
Month Day Year Month Day Year

AND HAS RECEIVED/WILL RECEIVE A DEGREE OF: _____ ON _____ 19___.

_____
Signature of Dean or Designated Official

School Seal

_____
Name and title (please type or print)

DATE: _____ 19_____

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

# Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.: 74712 Renewal Date: 01/19/2004

*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:

3. A) Mailing/Business Address:
JAMES ADAM GREENBERG
1153 Centre Street
Boston, MA 02130

OCT 31 2003

B) Home Address:

Home Phone:

Business Phone:

**Please make corrections** (print)

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

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (212) 617-983-7003

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

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

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

5. a) Name of Medical School: New York University School of Medicine
b) Year Graduated: 1988 c) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| | 0 | |

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

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

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

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

Facility Code: 921 ✓ (AP) 50 % Facility Code: 168 ___ (AP) ___ % Facility Code: ___ ___ ___ / ___ (AP) ___ %
Facility Code: 048 ✓ (AP) 50 % Facility Code: ___ ___ ___ / ___ (AP) ___ % Facility Code: ___ ___ ___ / ___ (AP) ___ %
*If 999, print name(s):* _____

PRINT YOUR LAST NAME: Greenberg LICENSE NUMBER: 74712

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

Insurer's name. (Required): CRICO Policy dates: From: __/__/__ To: __/__/__

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

☐ Otherwise exempt Please explain exemption:

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

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

1) Average weekly hours involved in: A) inpatient care 24 hrs/wk B) outpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

## PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (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: [signature], MD Date: 10/28/03

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name:** JAMES ADAM GREENBERG **License No.:** 74712

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## PART A

**1) Current Status:** Active **Renewal Due Date:** 12/22/2005 **Birth Date:**

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

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

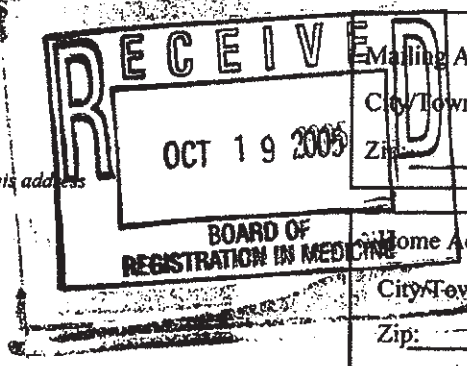
**2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses CANNOT be a Post Office Box.**

**Please make corrections (print)**

**2a) MAILING ADDRESS**
1153 Centre Street
Boston, MA 02130

☐ *Check here to change this address*

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




**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

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

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**
Brigham/Faulkner Ob/Gyn Assoc
1153 Centre St/Suite 36
Boston, MA 02130

Phone: (617)983-7003

☐ *Check here to change this address*

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

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 617-983-7499

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **Additional specialties:** |
|---|---|---|
| Obstetrics and Gynecology | ☐ | |
| | ☐ | |
| | ☐ | |

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

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

# Massachusetts Physician Renewal Application

**Physician Name:** JAMES ADAM GREENBERG **License No.:** 74712

| *(See Renewal Instructions, page 4.)* | *Please make corrections as necessary* |
|---|---|
| **7) Drug License Numbers, if any:** | **8a) Other states where you are <u>now</u> licensed to practice (Abbr.)** |
| a) Massachusetts: | ___ ___ ___ ___ ___ ___ ___ ___ |
| b) Federal (DEA): | **8b) States where you were <u>previously</u> licensed (Abbr.)** |
| c) Federal (DEA) XS: | ___ ___ ___ ___ ___ ___ ___ ___ |

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

Principal Work Setting: Private Office Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 32

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

**No Affiliations** ☐ 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 Current | Staff Category Change | *Approximate* # Hours per Week |
|---|---|---|---|---|
| Brigham & Women's Hospital | ☐ | Admitting | | 30 |
| Faulkner Hospital | ☐ | Admitting | | 32 |
| Massachusetts General Hospital | ☐ | Admitting | | 0 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

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

Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: _____ hrs/wk

b) outpatient care 30 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

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

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

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

<u>Check one:</u>

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____



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# Massachusetts Physician Renewal Application

**Physician Name: JAMES ADAM GREENBERG** **License No.: 74712**

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

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

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

| | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<br>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?<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Are there any criminal charges pending against you today?<br>c) Have any criminal offenses/charges against you been resolved during this time period? | | |
| **18)** Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? | | |
| **19)** Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| **20)** Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? | | |
| **21)** Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? | | |

**22) CME CERTIFICATION:**

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

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

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

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

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



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# Massachusetts Physician Renewal Application

**Physician Name: JAMES ADAM GREENBERG** **License No.: 74712**

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## 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: JG, MD Date: 10/18/05

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

# Massachusetts Physician Renewal Application

**Physician Name: JAMES ADAM GREENBERG** **License No.: 74712**

## 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.

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

☒ My current NPI is: 1 9 6 2 4 9 1 4 5 6

☐ 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.

## HIPAA TAXONOMY CODES

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

| | Taxonomy (Specialty) Code | Taxonomy Description (Print) |
|---|---|---|
| Primary Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | _____ |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | _____ |
| Provider Taxonomy: | ☐☐☐☐☐☐☐☐☐☐ | _____ |

## NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): _____ 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.

Signature: _____, MD Date: 10/18/05

**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: James Adam Greenberg, M.D.** **License No.: 74712**

## PART A

**1) Current Status:** Active **Renewal Due Date:** 12/22/2007 **Birth Date:**

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

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

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

**2a) MAILING ADDRESS**
1153 Centre Street
Boston, MA 02130

RECEIVED
DEC 4 2007
Board of Registration in Medicine

☐ *Check here to change this address*

**Please make corrections** (print)

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

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

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

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**
Brigham/Faulkner OB/GYN Assoc
1153 Centre St/Suite 36
Boston, MA 02130

Phone: (617)983-7003

☐ *Check here to change this address*

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

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 617-983-7499

**Correct your E-mail and Fax Number below:**

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **List Additional Specialties:** |
|---|---|---|
| Obstetrics and Gynecology | ☐ | |
| | ☐ | |
| | ☐ | |

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

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

# Massachusetts Physician Renewal Application

**Physician Name: James Adam Greenberg, M.D.** **License No.: 74712**

*(See Renewal Instructions, page 4.)*

**7) Drug License Numbers** **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

*Please make corrections as necessary*

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

_____

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

_____

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

| List the names of all work sites in Massachusetts *(See above and description on page 4.)* | Location (City or Town) | State | Delete? |
|---|---|---|---|
| Brigham & Women's Hospital | | | ☐ |
| Faulkner Hospital | | | ☐ |
| Massachusetts General Hospital | | | ☒ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: _____ hrs/wk

b) outpatient care 30 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2008 To 12/31/2008 1/1/07 - 12/31/07

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

**(Enclose a copy of the certificate of Insurance or the face sheet)**

JAG

☐ **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: James Adam Greenberg, M.D.** **License No.: 74712**

| *(See Renewal Instructions, page 4.)* | *Please make corrections as necessary* |
|---|---|
| **7) Drug License Numbers** **Corrections:**<br>a) Massachusetts: _____<br>b) Federal (DEA): _____<br>c) Federal (DEA) XS: _____ | **8) Other states where you are now licensed to practice**<br>_____<br>**9) States where you were previously licensed**<br>_____ |

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

| List the names of all work sites in Massachusetts *(See above and description on page 4.)* | Location (City or Town) | State | Delete? |
|---|---|---|---|
| Brigham & Women's Hospital | | | ☐ |
| Faulkner Hospital | | | ☐ |
| Massachusetts General Hospital | | | ☒ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: _____ hrs/wk

b) outpatient care 30 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 1/1/2008 To 12/31/2008

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: James Adam Greenberg, M.D.** **License No.: 74712**

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

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

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

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name: James Adam Greenberg, M.D.** **License No.: 74712**

## 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: 11/20/07

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

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

**Physician Name:** James Adam Greenberg, M.D. **License No.:** 74712

**Current Status:** Active **License Expiration Date:** 1/19/2010

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America

**Home Address:**

**Business Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America
(617) 983-7003

**3) Email Address:**

**4) Fax Number:** (617) 983-7499

**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**
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 |
|---|---|
| Brigham & Women's Hospital | |
| Faulkner Hospital | |

**Physician Name:** James Adam Greenberg, M.D. **License No.:** 74712

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 30 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2009 | 12/31/2009 | Claims made with tail coverage |
| CRICO | 01/01/2010 | 12/31/2010 | Claims made with tail coverage |

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

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

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

**16) Other Civil Lawsuits**
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

**Physician Name:** James Adam Greenberg, M.D. **License No.:** 74712

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:** James Adam Greenberg, M.D. **License No.:** 74712

## 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:** James Adam Greenberg, M.D. **License No.:** 74712

**Current Status:** Active **License Expiration Date:** 1/19/2012

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America

**Home Address:**

**Business Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America
(617) 983-7003

**3) Email Address:**

**4) Fax Number:** (617) 983-7499

**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**
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 |
|---|---|
| Brigham & Women's Hospital | |
| Faulkner Hospital | |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 30 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Controlled Risk Insurance Company of Verm | 01/01/2011 | 12/31/2012 | 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?**

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

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

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

**Physician Name:** James Adam Greenberg, M.D. **License No.:** 74712

## 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.

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

**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:** James Adam Greenberg, M.D. **License No.:** 74712

**Current Status:** Active **License Expiration Date:** 1/19/2014

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America

**Home Address:**

**Business Address:**
1153 Centre Street
Suite 36
Boston
Massachusetts - 02130
United States of America
(617) 983-7003

**3) Email Address:**

**4) Fax Number:** (617) 983-7499

**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**
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 |
|---|---|
| Brigham & Women's Hospital | |
| Faulkner Hospital | |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 12 hrs/wk
**b) outpatient care** 32 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2013 | 01/01/2014 | Occurrence Policy |
| CRICO | 01/01/2014 | 01/01/2015 | 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?

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

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

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

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

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

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

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

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

## Compliance with Legal Responsibilities

**Online profile:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR





October 29, 2001

REDACTED COPY

James Adam Greenberg, M.D.
1153 Centre Street
Boston, MA 02493

Re:

Docket Number: 01-395

Dear Dr. Greenberg:

The Complaint Committee of the Board met on October 24, 2001, and carefully considered the above referenced complaint. The members determined that no further action is warranted. The complaint has been dismissed.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort that you expended in preparing your response. If you have any questions, please call me at 617-727-1788, or write to me at the above address.

Very truly yours,

Kathleen M. Shea

Kathleen M. Shea
Consumer Protection Manager

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
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ROSCOE TRIMMIER, Esq.
REGIS DE SILVA, M.D.

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October 29, 2001

Re: James Adam Greenberg, M.D.
Docket Number: 01-395

Dear

The Complaint Committee of the Board of Registration in Medicine met on October 24, 2001, and carefully considered the information you furnished it regarding your complaint against the physician referenced above. A copy of your complaint was sent to the physician, who was required to respond in writing to the Board regarding the issues you raised.

After a thorough review of this evidence, the Committee determined that your complaint and the physician's response should be placed in the permanent record of the physician. While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions, I can be reached at the number or address listed above.

Thank you again for your concern.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR



October 11, 2001

Re: James A. Greenberg, M.D.
Docket Number 01-395

Dear

Enclosed please find a copy of Dr. Greenberg's response. You will be notified when there is a disposition in this matter.

If you have any questions, I can be reached at the number or address listed above.

Very truly yours,

Kathleen M. Shea
Consumer Protection Manager

KMS/bmh
Enclosure

Faulkner Hospital
*Brigham and Women's / Faulkner Hospitals*

HARVARD MEDICAL SCHOOL

**Division of Gynecology**
1153 Centre Street, Suite 37
Boston, MA 02130
Tel: 617 983-7003
Fax: 617 983-7499

**James A. Greenberg, M.D.**
Chief, Division of Gynecology
Faulkner Hospital
Vice Chairman, Department of
Obstetrics and Gynecology
Brigham & Women's Hospital

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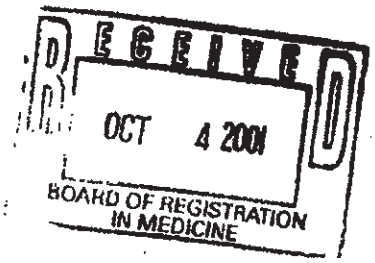
October 3, 2001




Kathleen M. Shea
Consumer Protection Manager
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Re:
Docket Number 01-395

Dear Ms. Shea,

It was with great personal sadness that I read the complaint filed against me by . While the exact events surrounding her pregnancies are not as clear to me as they were two years ago, I distinctly remember both , and her mother because of the extensive amount of time I spent speaking with them while was under my care. In fact, I believe , her mother and I had a much closer than usual physician-patient relationship prior to June 29th 1999. I have long sensed that this patient believed that her second pregnancy loss was my fault. While I do not in any way think I could have prevented her second tragic loss, this feeling of blame was always (and still is) very troubling to me.

With regards to the specifics of her complaints, I will try to address them as best I can. First, she implies that I took too long to see her with her first pregnancy. I do not know how to respond to this charge other than to say we routinely see patients for their first prenatal visits somewhere between 6 weeks and 12 weeks depending on when patients call, their "need" to come in and our office availability. In case, on her first prenatal visit she had no complaints but no fetal heart tones could be detected. An ultrasound performed that day at Boston Ultrasound revealed a blighted ovum (a pregnancy with no fetal pole). These results were discussed at length with both the patient and her mother and a D&E was scheduled and performed 36 hours later. I do not know how I could have prevented this first miscarriage but I spent considerable time and effort trying to comfort this patient about the loss and discussing her favorable prospects for future pregnancies.

With second pregnancy she was understandably nervous. To this end, at 8 weeks on 3/26/99 she had an ultrasound at Boston Ultrasound solely to confirm viability. The scan was completely normal with a good fetal heart rate. I do recall our collective joy with the finding of a good fetal heart beat. Three days later on 3/29/01 she was seen for her first prenatal visit in our

office and complained of some slight staining. An ultrasound was performed that day at Faulkner Hospital and showed a small perigestational hematoma but an otherwise appropriately growing fetal pole with a good heart rate. After that ultrasound, I tried to reassure the patient that most perigestational hematomas resolve without any untoward sequelae (which they do) and that I thought everything would be okay (which I did).

On 4/12/99 she was seen in the office at 10 weeks and a good fetal heart rate was heard. She was no longer bleeding. On 5/3/99 she was seen again in the office at 14 weeks and again a good fetal heart rate was heard. She was not bleeding at this time either and I think we all believed the pregnancy was progressing nicely despite the earlier bleeding. Unfortunately, 4 days later on Friday, 5/7/99 she again called complaining of bleeding. An ultrasound at Boston Ultrasound showed a well-growth fetus with a good heart rate but a lower limits of *normal* cervical length and some blood clots in the cervical opening suggestive of a placental abruption. She was evaluated immediately by my partner on Labor and Delivery at Brigham & Women's Hospital where her cervix was checked digitally. She was sent home on reduced activity and discontinued her job at that time. The following Monday, 5/10/99 her ultrasound was repeated at Boston Ultrasound and the cervical length was described as unchanged at the lower limits of *normal.* Some blood was still seen around the cervix. She was also re-examined in the office and her cervix was felt to be similarly unchanged.

Three days later on 5/13/99 she was seen again in the office complaining of bleeding. Her cervix was examined and unchanged. An ultrasound was scheduled for the next day, 5/14/99 at Brigham & Women's Hospital in order to get a second ultrasound opinion. This study showed a cervical length of 2.6cm with no funneling (completely normal) and a low-lying placenta with some clot in the cervical opening. This study seemed to explain the patients bleeding.

Her next visits were on 5/20/99 and 6/17/99 and she was doing well without any recurrent episodes of bleeding. On 6/17/99 she did have another follow-up ultrasound at Boston Ultrasound which was completely normal. During this examination, the ultrasonographer, considered doing a vaginal probe ultrasound examination to better determine the cervical length. Because of the patient's complicated history of bleeding throughout her pregnancy, called me to ask my opinion of the risks and benefits of doing a vaginal probe examination. It is important to note that never before and never since had ever called me to discuss doing a vaginal probe examination. On that day, she called because she was truly concerned about stirring up bleeding again. As best I can recall, I told that since the last ultrasound at Brigham & Women's had shown a normal cervical length and since the patient was not experiencing any worrisome symptoms at that time, it was my opinion that the risks of stirring up bleeding again were not worth it. and I have an excellent working relationship and I have no doubt that if she believed my judgment was grossly in error she would have said so. She did not. and her mother came to the office immediately after the ultrasound and we discussed my reasoning for this decision and they understood.

Two weeks later on 6/29/99 I had eye surgery. That day, at 22 weeks, the patient called complaining of cramping and a profuse discharge. She was seen in the office where her cervix was noted to be 3cm dilated with a bulging bag of water. She was sent to Brigham & Women's Hospital where my partner noted that she was leaking amniotic fluid. She delivered 8 hours later

and her baby died. Unfortunately, two weeks later she developed endometritis and was re-hospitalized for IV antibiotics. I do not recall ever coming in to see me or speak with me again.

Needless to say, I am very troubled about this particular patient's complaints. Contrary to her portrayal of my cold-hearted, lackadaisical care, I thought we had a trusting, communicative physician-patient relationship until her pregnancy ended with complications. At that time, decided that everything I had ever done was wrong.

Further, I spent a considerable amount of time discussing pregnancy with my partners and other colleagues and could not come up with the "answer." A cervical cerclage in May would have been contraindicated since she was bleeding. Also, since her cervix was never documented to be *abnormally* short or starting to open I am not sure a cerclage would have been appropriate even if she was not bleeding. I do not recall our discussions about her activity levels but she did stop working in May when her cervical length was normal and a hospitalization for bedrest with a closed cervix would have similarly not been appropriate.

In sum, I am upset about all that has transpired between and myself. I very much wanted everything to work out for her in her second pregnancy and her loss saddened me greatly. She was a very dependent patient and I know she was hurt that I was not there when she lost her pregnancy. I know she blames me for the loss and feels that I let her down but I still do not think that I could have reasonably prevented this outcome without the benefits of hindsight. Throughout both of her pregnancies I tried to listen to her concerns and be reassuring; I clearly failed. But, I do not believe my failure was out of ineptitude, disinterest or overwork.

Your cover letter states that persons filing complaints may have access to my response. I would ask that the Board make every effort to forward my response to so that she can at least understand that her loss was not forgotten and that at least some of her pain was shared.

Please do not hesitate to contact me further with questions the Board or this patient may have.

Thank you,

JG Greenberg, MD

James A. Greenberg, MD

Enclosure: Medical Records

# COMPLAINT FORM

Please type or print clearly, and provide all of the information requested.

☒ Mrs. ☐ Ms. ☐ Mr.

Your First Name | Your Last Name | Patient Name (if different)

Street Address | Mailing Address (if different)

City | State | Zip Code

Business/Daytime Phone | Home Phone

Complaint against M.D. X, D.O. ____, Acupuncturist ____.

**(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., Boston, MA 02114.)**

**This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.**

**Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.**

Dr. James A. Greenberg M.D.

Address

1153 Centre St Suite 36 Boston MA 02130

City | State | Zip Code

Business Phone

Brigham Faulkner OB GYN

Name and Location of Health Care Facility (if known)

**Nature of Complaint**

- ☒ Substandard Medical Care
- ☐ Professional Misconduct
- ☐ Sexual Misconduct
- ☐ Rude or Discourteous Behavior
- ☐ Impaired by Alcohol or Drugs
- ☐ Impaired by Mental or Emotional Illness
- ☐ Failure to Provide Medical Records
- ☐ Overcharge for Medical Records
- ☐ Drug Dealing
- ☐ Criminal Conviction
- ☐ Patient Neglect/Abandonment
- ☐ Unlawful Discrimination
- ☐ Billing for Services Not Rendered
- ☐ Failure to Supervise Staff
- ☐ False Advertising
- ☐ Fraud

☐ OTHER _____

Failure to complete and sign this release may prevent investigation of your complaint.

**Release of Medical Records and Information**

Patient Name. _____ Date of Birth: _____

Address: _____

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

**Signature of Patient.** _____ Date: 07/24/01
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

**Signature of Patient:** _____ Date: 07/24/01
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

Dr. James A. Greenberg
Boston Ultra Sound
Brigham + Women's Hospital

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative_____, ☐ Friend, ☐ Attorney, ☐ Other_____

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☒ Yes, ☐ No

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☒ No

How long have you (or patient) been under this physician's care? - Jan 1999 - Aug 1999
☐ 1 to 30 days, ☐ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☒ Commercial Insurance, ☐ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other_____

Are you (or patient) expected to pay a portion of this bill out of pocket?
☒ Yes, ☐ No We did

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☒ No

Is the fee or copayment in dispute?
☐ Yes, ☒ No

Has the physician been contacted about this complaint?
☐ Yes, ☒ No

Dates of Treatment: January 1999 - August 1999

04/17/09 16:01 266

escribe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

Attach copies of related documents to this form.
The information in this complaint is true, correct and complete to the best of my knowledge.

**Your signature:** _____ Date: 07/24/01

**Mail this form to:**

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111

I became a patient of Dr. James Greenberg in January of 1999. My Gynecologist had just decided to retire and recommended Dr. Greenberg to me. said that Dr. Greenberg was affiliated with Brigham and Women's Hospital which was just starting a partnership with the Faulkner Hospital in Boston. Dr. Greenberg would be maintaining an office in the Faulkner Hospital. I felt confident that Dr. Greenberg would be an excellent choice because Dr. highly recommended him. I had just found out that I was pregnant December 8, 1998 from a blood test by . I immediately got in contact with Dr. Greenberg's office to set up an appointment to see him. I was told that he starts to see his patients when the pregnancy is twelve weeks along. I set up the appointment. During this time, I felt very sick. I called Dr. Greenberg's office to find out what to do. They said it was normal and that I would see them at twelve weeks along. I went to him at twelve weeks along for the initial check up. Dr.Greenberg tried to hear the heart beat but could not find one. An ultrasound about an hour later confirmed that I had lost the pregnancy at about ten weeks along. We decided to have a D&C preformed at Brigham and Women's Hospital. I had that procedure on January 23, 1999.

I then became pregnant again with a baby which was due around November 1, 1999. This pregnancy was complicated from the start. I had bleeding at 8 weeks and again at 15 weeks. Each time I rushed into Brigham and Women's Hospital thinking that I had lost the pregnancy. I was holding the pregnancy and it seemed to me that they could not figure out why I was bleeding. I was having ultra sounds preformed at Boston Ultra Sound in Brookline,MA during this time. The doctors at Boston Ultra Sound noticed that my cervix seemed short. I had one ultra sound done at Brigham and Women's Hospital during this time that showed a low -lying placenta. The doctors at Boston Ultra Sound to my knowledge never saw that I had a low- lying

placenta.They felt that the cervix seemed short. With all these complications during the pregnancy and all the medical opinions about my condition being told to Dr. Greenberg he never once told me to have strict bed rest nor to stop working. I was not even hospitalized. It was very frustrating because I did not know what to do. I did not want to over react, I just wanted some straight answers and to be told what to do for my own health and the baby's health. I do not have a medical background and was depending on my doctor to take care of me. I had an ultra sound done on May 7, 1999 which showed that the cervix was short. , a wonderful doctor that I highly respect was suspicious that the cervix might be opening. I went back for another ultra sound on May 10, 1999. The cervix was still short. I was concerned. I asked Dr. Greenberg if I should stop working. He said "If I wanted to." I stopped working immediately. I started to take it easy but was not put on bed rest by Dr. Greenberg. My next ultra sound was on June 17, 1999. I was not feeling right. was concerned. We sat and talked about doing a transvaginal ultra sound to check the cervix. I was worried about having one preformed because it seemed every time I did I had bleeding afterward. said she would call over to Dr. Greenberg's office and ask him what he wanted her to do. I said I would do what he wanted. He told her not to do the transvaginal ultra sound and to send me over to him and that he would exam me. We both sat there and I said that he would send me back if he thought something was wrong. I went to Dr. Greenberg's office. He did not exam me. He looked at the results of the regular ultra sound that had performed and said." The placenta is not low-lying anymore it has moved." I said " thinks the cervix is short." He completely disregarded what Dr. said and wrote in her note to him about the cervix being short. He then said to me a statement that I will never forget to this day. " Why are you waiting for the other shoe to drop?" "Your fine." He then left the examination room. I was shocked. I didn't know what to do. Dr. Greenberg's nurse said to me " , if he thought something was wrong he

wouldn't let you go home." I left his office worried and upset. I went to the cafeteria with my mom and just felt that I did not know what to do.

Twelve days later my worst nightmare came true. I felt pain. I was not sure what it was. I first thought that maybe the baby was getting bigger and moving around. A little while later the pain became more intense . I rushed to Dr. Greenberg's office. His associate examined me. She saw that the cervix had opened and that one side of my water had broke and that I was 5 centimeters open. The baby was coming and there was no stopping it I delivered a baby girl named at 10:00 p.m. on June 1999. She weighed one pound and lived for 45 minutes. delivered the baby. Dr. Greenberg was unavailable to deliver the baby due to an eye operation.

The loss was devastating. I was released from the hospital and buried my child two days later. I had to return to the hospital two weeks later because I had what used to be called Mother's Fever. The summer of 1999 was a very difficult time in my life. I was going on with my life the best that I could but I had a persisting pain in my lower right side on an old appendix scar. The last time I saw Dr. Greenberg was in August of 1999. I went because this pain persisted and I was concerned because I was returning to my teaching position in September. Dr. Greenberg could not find out what was wrong. He said something to me inferring that the pain was psychological. That was the end of our Doctor\Patient relationship.

I found out later that the pain that I was feeling was old scar tissue being pulled from the pregnancy. It was not psychological.

We as a family were heart broken over the loss of our child and still feel the pain daily. I just feel that I should have had better care. I understand that it is hard to detect an incompetent cervix but I feel that Dr. Greenberg had enough information from all my tests and ultra sounds to know something was not right and to have least put me on strict bed rest or hospitalized me to save the baby. We informally discussed the

cerclage procedure but he and his associates were not eager to do that even though it could have been done that May. Dr. Greenberg in my opinion did not listen to my concerns or to the other doctors who were involved with my care during this pregnancy. I am an ordinary person with no medical background. I depended on this doctor to take care of me and my unborn child. It should not have been up to me to stop working or to decide heavy medical issues during this pregnancy. Dr. Greenberg took an oath to take care of his patients. I put my full trust in Dr. Greenberg and to this day I feel betrayed by him,his staff and associates.

I myself never gave up hope that I would be able to carry a child to term. I changed doctors in September of 1999. I found a wonderful doctor named along with and the Boston Ultra Sound Team of doctors listened to me and each other. They studied what had happened to me during my last pregnancy and his then partner placed a cerclage on my cervix at 14 weeks. This allowed me to carry a child to term. I gave birth to a beautiful, healthy baby boy on September 24, 2000.

I still have faith in the medical profession and I feel if Dr. Greenberg would slow down and listen to other peoples opinions and feelings gigantic, devastating medical mistakes that affect peoples lives forever would not happen.

Thank you for your time. If there is any more information you need from me before the medical board makes a decision about this case please let me know.I look forward to hearing a response about this serious complaint.

Sincerely,