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

Physician Registration Renewal Application

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

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

OCT 1 0 2001
BOARD OF REGISTRATION IN MEDICINE

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

REDACTED COPY

1. Current Status: Active Registration No.: 48484 Renewal Date: 12/09/2001

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

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

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

3. A) Mailing/Business Address:
ROBERT BARBIERI
BRIGHAM & WOMEN'S
75 FRANCIS STREET
BOSTON, MA 02115

B) Home Address:

Home Phone:

Business Phone: (617)732-4265

Please make corrections (type or print)

Other Name(s): _____

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

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

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: Harvard Medical School

b) Year Graduated: 1977 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
IM	40	Internal Medicine
OBG	0	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 were previously licensed (Abbr.)
NY

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) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: BARBIERI LICENSE NUMBER: 48484

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: CRICO - RISK MANAGEMENT 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 10 .
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 8 hrs/wk b) inpatient care 8 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 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: Robert Barbieri Date: 10/6/01

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.

I. PHYSICIAN INFORMATION

ROBERT (*First Name*) | (*Middle Initial*) | BARBIERI (*Last Name*) | (*Suffix*)

Make changes to name here

Mass License # 48484
License Status Active

First Issue Date 10/06/81

Hospital Affiliation

Brigham & Women's Hospital

Brigham & Women's
75 Francis Street
Boston, MA 02115
U.S.A.
(617) 732-5444

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:
MOST MAJOR INSURANCE ACCEPTED

Licenses Held in Other States:

(Please correct as necessary)

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

II. EDUCATION & TRAINING

Harvard Medical School (*Medical School*) | MD (*Degree*) | 77 (*Date*)

Make corrections here

Residency Program(s) — *Start* — *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 Internal Medicine

Certifying Board Name: Board of Obstetrics and Gynecology

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. BARBIERI

No. of Years in Practice: #

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
KATE MACY LADD PROFESSOR	.....
OB-GYN, HARVARD UNIVERSITY	.....
.....	.....
.....	.....
.....	.....
.....	.....

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
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
48484	ACTIVE	$250.00	12/09/95	$25.00

Mailing Address:

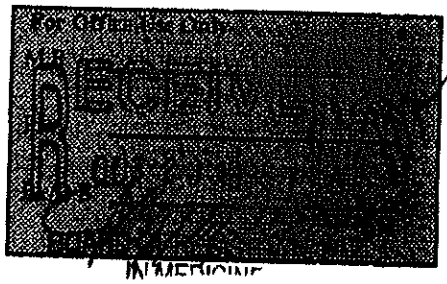
ROBERT BARBIERI, M.D.
BRIGHAM & WOMEN'S
75 FRANCIS ST DEPT OBGYN
BOSTON, MA 02115

Correction of Mailing Address

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

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

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



Pre-Printed Information

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

2. Home Address:

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

Home Phone: Business Phone: (617) 732-5444

4. Name of Medical School: Harvard Medical School
   Year Graduated: 77 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	0	Obstetrics and Gynecology

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

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): 10/6/81 SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
_____	_____
_____	_____

If OS, print specialty: _____

Code: _____ 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: BARBIERI Registration Number: 48484

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

Facility Code: ___ / ___ (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 how otherwise exempt: _____

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

13. a) What is your principal work setting? (See Table 4) 10

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? 6 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.) 20 %

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: ROBERT BARBIERI Date: 10/21/95

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
45424	ACTIVE	$250.00	12/09/93	$25.00

Mailing Address:
ROBERT MARSIERI, M.D.
BRIGHAM & WOMEN'S
75 FRANCIS ST DEPT OBGYN
BOSTON, MA 02115

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

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

For Office Use Only
M.R. OCT 18 1993
Pr.
Bk/D.E.

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   BRIGHAM & WOMEN'S
   75 FRANCIS STREET
   BOSTON, MA 02115

3. Date of Birth: / / Sex: M
   Lic. Issue Date: / / SS#:
   Telephone Number:
   Home: Business: (617) 732-4648

4. Name of Medical School:
   Harvard Medical School
   Year Graduated: 77 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.	
OBG	0	Obstetrics and Gynecology
	0	

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: IM Code: OG
   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)

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): _____
City/Town: _____
Country Code: _____ If 999 print Country: _____

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____
Telephone Number:
Home: _____ Business: (617) 732 5444

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): _____

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.

Staple Check Here

EN

PRINT NAME AND NUMBER: Physician Last Name: BARBIERI Registration Number: 48484

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: 9 2 1 / ✓ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)
Facility Code: ___ ___ ___ / ___ (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) 1 0

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? 20 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: Robert Barbieri Date: 10/14/93

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

019461

Board Use Only:

Registration No.	Status	Fee	Renewal Date
		$150	

OCT 1989 RECEIVED

M.R. 11/9/89
Pr.
Bk.
Ch.
D.E. 11/3/89
Fl.

NOV 1989

Important:

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

1. a) Name (LAST:) BARBIERI (FIRST:) ROBERT (M.I.:)

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

2. a) Address (Mailing):

2. b) Address (Home):

2. c) Address (Business): 75 FRANCIS ST
BOSTON MA 02115

2. d) Telephone (Business): (617) 732-4648 Extension 2. e) Telephone (Home) *(Optional)*:

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

6. a) Medical School Code *(See Table 1)*: MA001 *If 99999, write* Name:

6. b) Year Graduated: 77 6. c) Degree: M.D. ✓ D.O.

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

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

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

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

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

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

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

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

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

Facility Code: 921 100 %	Facility Code: %	Facility Code: %
Facility Code: %	Facility Code: %	Facility Code: %

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: 168	Facility Code:	Facility Code:	Facility Code:

If 999, write Name(s):

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

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

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

Signature: ROBERT BARBIERI BARBIERI Date: 10/10/89

(989 revised 3/89)

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

Fill in name and number. **Physician Last Name:** BARBIERI **Registration No.:** 48484

12. a) Other States where you are now licensed to practice *(Abbreviate)*: NONE

12. b) States where you previously were licensed to practice (Abbreviate): NONE

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

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 100+ hrs., Category II: _____ hrs., (Risk-Management: [redacted] hrs.); Residency Program In: _____
Waiver Requested___ (You must fill out a separate Waiver Form.) (123) 5+ CATEGORY 1 6- CATEGORY 2

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER X LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer: CRICO Institution Issuing Letter of Credit: _____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE___ OTHERWISE EXEMPTED___ *(State how)* _____

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

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

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

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

****

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

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

BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC. NUMBER, OPTIONAL ___-___-____

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☐
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
[illegible]	.	[illegible]	$100	100	[illegible]	[illegible]	[illegible]	

[illegible] PATIENT

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

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: ROBERT BARBIERI
2. Date of Birth: ___ (MONTH / DAY / YEAR)
3. Medical School: HARVARD M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: USA
5. Date of Graduation: 6/1/77
6. American Specialty Board Certified? ☑ (Check if yes.)
   Which Boards? INTERNAL MEDICINE, ENDOCRINOLOGY AND METABOLISM
7. Principal Specialty(ies): REPRODUCTIVE ENDOCRINE
8. Principal work setting: BRIGHAM AND WOMEN'S HOSP
9. Home address: ___
10. Principal business address: 75 FRANCIS ST BOSTON MA 02115
11. List all hospitals at which you have currently effective privileges: BRIGHAM AND WOMEN'S HOSPITAL
12. List all hospitals at which you have held privileges in the past 20 years: MASS GENERAL HOSPITAL,
13. States other than Massachusetts in which you are presently licensed to practice: NONE
14. List any other states where you were previously licensed to practice: NONE

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: 100 HOURS CATEGORY 1; BRIGHAM AND WOMEN'S, HARVARD MEDICAL SCHOOL; PLUS 5 RISK MANAGEMENT
26. I am an active ☑ Inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

ROBERT BARBIERI
SIGNATURE

DATE: 10-15-87

(See Reverse Side)

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

Board Use Only:
Registration No. | Status | Fee $375.00 | Renewal Date

OK
To Peter and Susan 7/30/93 FP
Peter Ahern OK on 8/04/93 FP

M.R.
Pr. FP
Bk.
Ch. #325
D.E. #25
Fl.
#350 Fed.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--it is not adequate to state that the Board already has the information.*
- *Sign the application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $325 fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) BARBIERI (FIRST:) ROBERT (M.I.:)

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

2. a) Address (Mailing): DEPT OB GYN, BRIGHAM AND WOMEN'S HOSPITAL
75 FRANCIS ST, BOSTON MA 02115

2. b) Address (Home):

2. c) Address (Business): DEPT OB GYN, BRIGHAM AND WOMEN'S HOSPITAL
75 FRANCIS ST, BOSTON MA 02115

2. d) Telephone (Business): (617) 732-5494 Extension 2. e) Telephone (Home) *(Optional)*: (___) ___-____

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

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

6. b) Year Graduated: 1977 6. c) Degree: M.D. ✓ D.O.

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

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

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

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

10 Resident or Fellow	____%	20 Practice Involving Direct Patient Care	25 %	8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): / / 1980
30 Administrative Activities	50 %	40 Medical Teaching	____%	
50 Medical Research	25 %	99 Other	____%	

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 100 % Specialty Code: IM Percent of Practice Time: 0 %
If OS, specify:

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

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

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*
Facility Code: 921 100 % Facility Code: ____ ____% Facility Code: ____ ____%
Facility Code: ____ ____% Facility Code: ____ ____% Facility Code: ____ ____%

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 20 years. *(See Table 4.)*
Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write Name(s):

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

Pursuant to M.G.L. 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 hereby certify under the penalties of perjury that all information on this form--front and back and (#) ____ attached pages--is true.

Signature: Robert Barbieri Date: 7/20/93

(See reverse side)

Massachusetts Board of Registration in Medicine Lapsed License Application, Page 2 of 2

Fill in name and number. **Physician Last Name:** ROBERT BARBIERI **Registration No.:** 48484

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

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

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

14. a) I have completed my C.M.E. requirements as follows: *(Fill in # of hours or type of residency, or check waiver.)* Category I: 50 hrs., Category II: 50 hrs., (Risk-Management: 10 hrs.); Residency Program in: _____; Waiver Requested ___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT ___. *If applicable, check one and identify the name.* Insurer: CRICO Institution issuing Letter of Credit: _____ *Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)* NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* _____

14. c) Percent of Practice Time in Massachusetts: 100 % 14. d) Have you practiced medicine actively and regularly since your license lapsed in Massachusetts? (Y/N) Y If No, please attach a letter of explanation. AS OF 4/97

Questions 15 through 17: Check either YES or NO (not N/A) to each question. Provide details on Form 18A, attached.

	Yes	No
15. Has any medical malpractice claim been made against you on or after Jan. 1, 1976 (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than 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 on or after Jan. 1, 1976 by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 18A, attached.

Questions 18 - 24: Check either YES or NO (not N/A) to each question. Provide details in the next section.

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

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Fee -$300.00 to be submitted

Filed: 6-25 | For Office Use | Application # _____
By: PF
Form of Fee: 350 | Certificate # _____ | Date of Issue _____

Please Print **SWORN STATEMENT** Date: 6-11-93

Name ROBERT (First) BARBIERI (Middle) (Last)
Date of Birth _____
Place of Birth ASTORIA N.Y.
Name on Birth Certificate ROBERT BARBIERI

Address DEPT OB-GYN
BRIGHAM AND WOMEN'S HOSPITAL
75 FRANCIS ST, BOSTON MA 02115
Phone # 617-732-5444

Pre-Medical Education
School YALE College
Years Attended 9/69 to 6/73

Medical Education
School HARVARD MEDICAL SCHOOL
Years Attended 9/73 to 6/77

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
PETER BENT BRIGHAM	- RESIDENT	7/77 to 6/80
BRIGHAM AND WOMEN'S	- RESIDENT	7/80 to 6/84
BRIGHAM AND WOMEN'S	- FELLOW	7/84 to 6/86
BRIGHAM AND WOMEN'S	- ATTENDING	7/86 to 2/90
UNIVERSITY HOSPITAL, STONY BROOK,	- Chief OB/Gyn	2/90 to PRESENT

Is this your first full license? No If applicable, please list all other states where your are or have been licensed:
MASSACHUSETTS (# 48484), NEW YORK (181331)

Other names under which you have been licensed:
_____

List Specialty Boards by which you are certified: AMERICAN BOARD INTERNAL MEDICINE, AMERICAN BOARD OB-GYN

REASON APPLYING FOR A MA LICENSE NEW JOB AT BRIGHAM AND WOMEN'S
Anticipated starting date if you have position pending in Massachusetts: 9/1/93

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

RECEIVED BOARD OF MEDICINE

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

ROBERT BARBIERI Date: 6/11/93
SIGNATURE OF APPLICANT

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR MA / MD LICENSE

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: ROBERT BARBIERI Day time phone #: 617 732 5444

MAILING ADDRESS: DEPT OF GYN; BRIGHAM AND WOMEN'S HOSPITAL, 75 FRANCIS ST BOSTON MA 02115

Business Address:

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (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? If so, previous name: _____		
4. 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 (see definition) at an academic institution since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, 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 (see definition)?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) 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?		
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. _____ _____ _____ _____		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

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

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 full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: ROBERT BARBIERI DATE: 6-11-93

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

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

FORM E

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this 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. Thank you for your cooperation.

I CERTIFY THAT ROBERT BARBIERI (HMS 77) CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

YALE COLLEGE
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: HARVARD MEDICAL SCHOOL
NAME OF MEDICAL SCHOOL

BOSTON MA 02115
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT ROBERT BARBIERI
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: HARVARD MEDICAL SCHOOL
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

FORM E CONTINUED

NAME OF APPLICANT HARVARD MEDICAL SCHOOL

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

	MONTH	DAY	YEAR	TO: MONTH	DAY	YEAR
FROM:	September	6	1973	August	31	1974
FROM:	September	1	1974	August	31	1975
FROM:	September	1	1975	August	31	1976
FROM:	September	1	1976	June	16	1977
FROM:						
FROM:						
FROM:						

AND HAS RECEIVED/~~WILL RECEIVE~~ A DEGREEE OF MD

ON June 16, 19 77.

Carol A Duffey
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Carol A. Duffey, Registrar
NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE: June 30, 1993

Certification of Post-Graduate Training

FORM G

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

I, KENNETH J. RYAN MD, CHAIRMAN, DEPT. OF OB/GYN
(Name) (Title)

hereby certify that ROBERT BARBIERI has served 3 year(s) of post-graduate training as a RESIDENT (Position) in OB-GYN (Specialty) at BRIGHAM AND WOMEN'S (Hospital), BOSTON (City), MA (State).

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

Dr. BARBIERI participated in this program from 7 (Month), 80 (Year) to 6 (Month), 84 (Year) and was issued ✓ was not issued _____ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

_____

_____

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

_____
Signature of Director

6/25/93
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Certification of Post-Graduate Training FORM G

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

I, KENNETH J. RYAN, M.D. (Name), CHAIRMAN, DEPT. OF OB/GYN (Title)

hereby certify that ROBERT BARBIERI has served 2 year(s) of post-graduate training as a FELLOW (Position) in REPRO ENDOCRINOLOGY (Specialty)

at BRIGHAM AND WOMEN'S (Hospital), BOSTON (City), MA (State).

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

Dr. BARBIERI participated in this program from 7 (Month), 84 (Year) to 7 (Month), 86 (Year) and was issued ✓ was not issued _____ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

_____

_____

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

_____
Signature of Director

6-25-93
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Certification of Post-Graduate Training FORM G

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

I, Marshall A. Wolf, M.D. (Name), Assoc Phys-in-Chief (Title)

hereby certify that ROBERT BARBIERI has served 3 year(s) of post-graduate training as a INTERN RESIDENT (Position) in MEDICINE (Specialty)

at PETER BENT BRIGHAM (Hospital), BOSTON (City), MA (State).

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

Dr. ROBERT BARBIERI participated in this program from 7 (Month), 77 (Year) to 6 (Month), 80 (Year) and was issued ✓ was not issued _____ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

_____

_____

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

Marshall Wolf
Signature of Director

6/28/87
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Massachusetts Board of Registration in Medicine
Physician Profile

ROBERT BARBIERI, MD

I. Physician Information

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

Dr. Barbieri has been in practice in Massachusetts: 15 years

Accepting new patients? Yes Accepts Medicaid? Yes

Primary work setting: Hospital

Business address: BRIGHAM & WOMEN'S
75 FRANCIS STREET
BOSTON, MA 02115-
Phone: 617-732-5444

Translation services available: ~~None~~ Most languages available on request.

Insurance Plans Accepted

~~No insurance plans reported~~ See attached list

Hospital Affiliations

Brigham & Women's Hospital

II. Education & Training

Medical School: Harvard Medical School
Graduation Date: 1977

Post Graduate Training: ~~None Reported~~

7/1/77 - 6/30/80 - PETER Bent Brigham Hospital
7/1/80 - 6/30/84 - Brigham + Women's
7/1/84 - 6/30/86 - Brigham + Women's

III. Specialty

Obstetrics and Gynecology; REPRODUCTIVE ENDOCRINOLOGY
ABMS Board Certified: Board of Internal Medicine
Board of Obstetrics and Gynecology
BOARD of ENDOCRINOLOGY AND METABOLISM

IV. Honors and Awards

KATE MACY LADD PROFESSOR OB-GYN, HARVARD UNIV
Chief OB Gyn; BRIGHAM AND WOMEN'S HOSPITAL

V. Professional Publications

OVER 200 publications

~~This physician has reported no publications.~~

VI. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

* Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
* This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
* The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
* Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
* Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

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

VII. Disciplinary Actions

A. Criminal Convictions

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

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

B. Hospital Discipline

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

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

C. Board Discipline

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

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

INSURANCE PLANS ACCEPTED

1. AETNA
2. BLUE CROSS/SHIELD PRODUCTS
3. HMO BLUE
4. HARVARD PILGRIM HEALTH CARE
5. TUFTS HEALTH PLAN
6. HEALTH CARE VALUE MANAGEMENT
7. METRAHEALTH
8. NEIGHBORHOOD HEALTH PLAN
9. HEALTHY START
10. ALL OTHER MAJOR HEALTH INSURANCE PLANS

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

CBJ 11-4-97

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
BOARD OF REGISTRATION IN MEDICINE
OCT 27 1997

Registration No.: 48484 Renewal Date: 12/09/97

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

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

Corrections (type or print)

3. A) Mailing/Business Address:
ROBERT BARBIERI, M.D.
BRIGHAM & WOMEN'S
75 FRANCIS ST DEPT OBGYN
BOSTON, MA 02115

B) Home Address:

State:

State:

Home Phone:
Business Phone: (617)732-5444

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 10/06/81 D) SS#:

(M/F):
#:

5. A) Name of Medical School:
Harvard Medical School

B) Year Graduated: 77 C) Degree: MD

Year Graduated: Degree (MD/DO):

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

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

Code(s)	Hours Per Week in Mass.
	40 hours

If OS, Print Specialty:

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

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: New York - NY

Abbr:
Abbr: N Y

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

PRINT NAME AND NUMBER: Last Name: ROBERT BARBIERI Registration Number: 48489

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

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

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

11. My medical malpractice insurance is covered by a) ✓ 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 0

B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 35 hrs/wk b) inpatient care 5 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care ? 20 %

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 ROBERT BARBIERI Date: 10/24/97

BOARD OF REGISTRATION IN MEDICINE
ROOM 1507 — 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
1986-1988

IMPORTANT -- READ, COMPLETE AND SIGN —

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW

SOC SEC NO. OPTIONAL [redacted]

YOU MUST SIGN BELOW

X [redacted]
APPLICANT'S SIGNATURE

SEE REVERSE SIDE

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, YOU MUST CHECK THIS BOX: ☐

PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		48484	100.00	100.00	01	15	86	

DO NOT FOLD OR STAPLE THIS FORM

ROBERT BARBIERI

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

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

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
P.O. BOX 6
BOSTON, MASSACHUSETTS 02297

3500600484840 011586 10000000004

Print Name ROBERT BARBIERI Date of Birth

Medical School HARVARD Date of Graduation: 6/77

You must read the instructions enclosed with this form to answer questions 1-12

1. Principal Specialty(ies) ENDOCRINOLOGY, OB-GYN
2. Principal work setting MEDICAL SCHOOL
3. Home address SAME AS FRONT
4. Principal business address 45 SHATTUCK ST BOSTON MA 02115
5. List all hospitals at which you have currently effective privileges BRIGHAM + WOMEN'S HOSPITAL
6. States other than Massachusetts in which you are licensed to practice: NONE

	YES	NO
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?		
8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?		
9. 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. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows (h) REPRODUCTIVE ENDOCRINOLOGY FELLOW — BRIGHAM'S WOMEN'S HOSPITAL 1984-1986

12. I am an active (Y) inactive practitioner (Check one)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE Robert Barbieri

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

DIVISION OF REGISTRATION
ROOM 1520 — 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
BOARD OF REGISTRATION
IN MEDICINE

AS A REGISTERED
PHYSICIAN

IMPORTANT — READ, COMPLETE AND SIGN —

PURSUANT TO M.G.L. C.62C, S.49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO OR FEDERAL ID NO

YOU MUST SIGN BELOW

X Robert Barbieri
APPLICANT'S SIGNATURE

MY SIGNATURE ON THIS RENEWAL APPLICATION INDICATES THAT I ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY TO THE COMPLETION OF CONTINUING EDUCATION REQUIREMENTS IN COMPLIANCE WITH THE BOARD'S STATUTES AND/OR RULES AND REGULATIONS.

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		48484	100.00	100.00	01	15	84	

PLEASE USE THE ENCLOSED RETURN ENVELOPE

Note! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A CERTIFIED CHECK OR MONEY ORDER — PAYABLE TO:

COMM. OF MASS.
P.O. BOX 6
BOSTON, MASS. 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

DO NOT FOLD OR STAPLE THIS FORM

ROBERT BARBIERI

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

3500600484840 011584 10000000009

1. Principal Specialty(s): * | 1 | 5 | 0 | 9 |

2. Principal work setting: * | 4 | 8 |

3. Home Address:

4. Primary work address: 75 FRANCIS ST
BOSTON 02115

5. States other than Massachusetts in which you are licensed to practice N/A

	YES	NO
6. Has a judgment ever been returned against you in a malpractice suit since 1/15/82?		
7. Have you ever been convicted of any criminal offense other than minor traffic offenses?		
8. Has any disciplinary action been taken against you in this state or any other?		
9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows: * | 0 | 6 |

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE.

Robert Bamborian
SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

*SEE OVER SHEET

Massachusetts Physician Renewal Application

Physician Name: ROBERT BARBIERI **License No.:** 48484

PART A

1) Current Status: Active **Renewal Due Date:** 11/11/2005 **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.

2a) MAILING ADDRESS
BRIGHAM & WOMEN'S
75 FRANCIS STREET
BOSTON, MA 02482

☑ *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 & WOMEN'S
75 FRANCIS STREET
BOSTON, MA 02482

Phone: (617)732-4265

☐ *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: 617-277-1440

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?**
Internal Medicine	ABMS	Internal Medicine	☑	☐
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☑	☐
ENDOCRINOLOGY, DIABETES, METABOLISM	ABMS		☐	☐
REPRODUCTIVE ENDOCRINOLOGY + INFERTILITY	ABMS		☐	☐

Massachusetts Physician Renewal Application

Physician Name: ROBERT BARBIERI **License No.: 48484**

(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:	NY ___ ___ ___ ___ ___ ___ ___

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

Principal Work Setting: Hospital Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 55 hrs/wk

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		55
Newton-Wellesley Hospital	☐			1
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 8 hrs/wk Change to: 12 hrs/wk

b) outpatient care 5 hrs/wk Change to: 6 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)*: _____

Massachusetts Physician Renewal Application

Physician Name: ROBERT BARBIERI **License No.:** 48484

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 a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: ROBERT BARBIERI **License No.: 48484**

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: Robert Barbieri Date: 9/1/2005

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: ROBERT BARBIERI **License No.: 48484**

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: 1548253958

☐ 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): NY 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: Robert Barb Date: 9/1/2005

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

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.:48484 Renewal Date:12/09/2003

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

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

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

3. A) Mailing/Business Address:
ROBERT BARBIERI
BRIGHAM & WOMEN'S
75 FRANCIS STREET
BOSTON, MA 02482

B) Home Address:

OCT 14 2003

Home Phone:

Business Phone: (617)732-4265

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: (_____) _____

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:
Harvard Medical School
b) Year Graduated: 1977 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: IM Code: OG

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

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

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

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) 99 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
Facility Code: 75 / ✓ (AP) 1 % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: ROBERT BARBIERI LICENSE NUMBER: 48484

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

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

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

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 0 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 8 hrs/wk B) outpatient care 5 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: ROBERT BARBIERI Date: 10/8/03

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.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

Current Status: Active **License Expiration Date:** 12/9/2009

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Brigham & Women's
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:
Brigham & Women'S
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America
(617) 732-4265

3) Email Address:

4) Fax Number: (617) 277-1440

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	Internal Medicine	Internal Medicine	
ABMS	Internal Medicine	Internal Medicine	Endocrinology, Diabetes & Metab
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	Reproductive Endocrinology

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
New York

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

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

WorkSite	Location
Brigham & Women's Hospital	Boston
Newton-Wellesley Hospital	Newton

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 6 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

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?

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

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?**

Massachusetts Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

PART A

1) Current Status: Active **Renewal Due Date:** 11/11/2007 **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
Brigham & Women'S
75 Francis St Dept Obgyn
Boston, MA 02482

☐ *Check here to change this address*

2b) HOME ADDRESS

RECEIVED
SEP 14 2007
Board of Registration in Medicine

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
Brigham & Women'S
75 Francis Street
Boston, MA 02482

Phone: (617)732-4265

☐ *Check here to change this address*

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 617-277-1440

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?**
Internal Medicine	ABMS	Internal Medicine	☐
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology - Reproductive Endocrinology	☐
Internal Medicine	ABMS	Internal Medicine - Endocrinology, Diabetes & Metabolism	☐

Massachusetts Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.: 48484**

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

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	Boston	MA	☐
Newton-Wellesley Hospital	Newton	MA	☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 12 hrs/wk Change to: _____ hrs/wk

b) outpatient care 6 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: CRICO Change to: _____

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

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.: 48484**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.: 48484**

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: Robert Barbieri Date: 9/13/2007

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
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 OCT -4 1999 Board of Registration in Medicine

Registration No.: 48484 Renewal Date: 12/09/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
ROBERT BARBIERI
BRIGHAM & WOMEN'S
75 FRANCIS ST DEPT OBGYN
BOSTON, MA 02115

B) Home Address:

Home Phone:
Business Phone:

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

5. A) Name of Medical School:
Harvard Medical School

B) Year Graduated: 1977 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: _____
City/Town: _____ State: _____
Zip: _____ Country: _____

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

Home: (____) _____
Business: (617) 732 4265

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
	20
If OS, Print Specialty:	

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

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: NY

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

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

PRINT NAME AND NUMBER: Last Name: BARBIERI Registration Number: 48484

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) 100 % Facility Code: ___ ___ / ___ (AP) ____% Facility Code: ___ ___ / ___ (AP) ____%

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

If 999, print name(s): _____

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

Name of Insurer: CRICO Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 0

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

1) Average weekly hours involved in: a) outpatient care 10 hrs/wk b) inpatient care 10 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: ROBERT BARBIERI Date: 10/1/99

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

Current Status: Active **License Expiration Date:** 12/9/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Brigham & Women's
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:
Brigham & Women's
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America
(617) 732-4265

3) Email Address:

4) Fax Number: (617) 277-1440

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	Internal Medicine	Internal Medicine	
ABMS	Internal Medicine	Internal Medicine	Endocrinology, Diabetes & Metab
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	Reproductive Endocrinology/Infer

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
New York

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

WorkSite	Location
Brigham & Women's Hospital	Boston
Newton-Wellesley Hospital	Newton

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 6 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2011	12/31/2011	Claims made with tail coverage

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

Compliance with Legal Responsibilities

Online profile:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

Current Status: Active **License Expiration Date:** 12/9/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Brigham & Women's
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:
Brigham & Women'S
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America
(617) 732-4265

3) **Email Address:**

4) **Fax Number:** (617) 277-1440

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	Internal Medicine	Internal Medicine	
ABMS	Internal Medicine	Internal Medicine	Endocrinology, Diabetes & Metab
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	Reproductive Endocrinology/Infer

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

Physician Name: Robert Barbieri, M.D. **License No.:** 48484

WorkSite	Location
Brigham & Women's Hospital	Boston
Newton-Wellesley Hospital	Newton

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 6 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2013	12/31/2013	Claims made with tail coverage

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

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

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

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

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a) Have you been charged with any criminal offense during this period?
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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: Robert Barbieri, M.D. **License No.:** 48484

Current Status: Active **License Expiration Date:** 12/9/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Brigham & Women's Hospital
75 Francis St Dept Obgyn
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:
Brigham & Women's Hospital
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Massachusetts - 02115
United States of America
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18) Other Issues
a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

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

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

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

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse
Have you completed training to recognize and report suspected child abuse or neglect?