

33-1-18

STATE OF ALABAMA
MEDICAL LICENSURE COMMISSION
POST OFFICE BOX 887
MONTGOMERY, ALABAMA 36101-0887

JAMES E. WEST, M.D.
CHAIRMAN/EXECUTIVE OFFICER

KAREN SILAS
EXECUTIVE ASSISTANT

TELEPHONE
(334) 242-4153

APPLICATION FOR LICENSE TO PRACTICE MEDICINE/OSTEOPATHY

NAME IN FULL: Carr Ellis Sacheen
(Last Name) (First Name) (Middle Name)

HOME ADDRESS: 210 Lincoln St, 503

CITY: Boston STATE: MA ZIP CODE: 02111

COUNTY: Suffolk TELEPHONE: (617) 519 4323

TYPE OF PRACTICE: OB/GYN

ALABAMA PRACTICE ADDRESS: 717 Down Turner Loop W
Mobile AL 36609

CITY: Mobile STATE: AL ZIP CODE: 36609

COUNTY: Mobile TELEPHONE: (866) 865-7748

EMAIL ADDRESS: scarrelis@gmail.com

DATE: 5/29/2014 SIGNATURE: [Signature] M.D.
Specify One: MD/DO/Limited License

Please specify the following:

Public Address: Home Address Practice Address
Mailing Address: Home Address Practice Address

**PLEASE ATTACH LICENSE FEE OF \$75.00
MAKE CHECK PAYABLE TO MEDICAL LICENSURE COMMISSION OF ALABAMA**

Rule 540-X-3-.21, effective August 30, 1999 states that "a certificate of qualification issued by the Board shall be withdrawn by the Board after a period of six (6) months from the date of issuance unless the applicant has filed an application for a license to practice medicine with the Medical Licensure Commission of Alabama and paid the required fee.

Please notify the Commission within 15 days of a change of address

For Office Use Only:
Board Agenda - Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec



Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2015 Online Renewal Summary

Name: **Sacheen Carr Ellis null**

License Number: **MD.33448**

Transaction Date: **2014-10-13***

Transaction Number: **VLFAB6120E1B**

Registration Fee: **300**

Date of Birth: **1973-04-02**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

Under Alabama law, this document is a public record and if requested it will be provided in its entirety.

What is your Physical Address? (No PO Boxes)

Street **717 DOWNTOWNER LOOP W**

City **MOBILE**

State **Alabama**

Zip **36609**

County (If not in Alabama Choose 'Out of State' **Mobile**)

Country **United States**

What is your Mailing Address?

Street **210 LINCOLN ST**

Apt/Suite **APT 503**

City **BOSTON**

State **Massachusetts**

Zip **02111**

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County (If not in Alabama Choose 'Out of State' **Out of State**)

Country **United States**

The Medical Licensure Commission (MLC) and the Alabama Department of Public Health (ADPH) are requesting a valid email address on each physician for the purpose of sending official license information and appropriate Health Alert Network (HAN) messages. The purpose of a HAN is to share urgent public health information about emerging situations. Email addresses will not be sold or disseminated for any other purpose

What is your practice Email? **sacheen.ellis@ppse.org**

What is your practice Telephone? **866-865-7748**

What is your Home Email? **scarrellis@gmail.com**

What is your Home Phone? **617-519-4323**

Please choose which address you would like to be your MAILING ADDRESS. The mailing address will be the address that the Board and Commission will use to mail all communications to the Licensee. (Examples: Renewal Certificates, Renewal Notices, Important Notices from the Board or Commission, etc) IMPORTANT NOTE: By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website. NOTE: Under Alabama law, this renewal is a public record and if requested it will include this address. **Mailing**

Please choose which address you would like to be your PUBLIC ADDRESS. The public address will be the address given out if an address is requested. IMPORTANT NOTE: If a valid public address is not provided then the mailing address will be given out instead of the public address. By law you are required to notify the Board and the Commission of change in address within 15 days of that change. Change of Address can be submitted using the Change of Address form found on the www.albme.org website. NOTE: Under Alabama law, this renewal is a public record and if requested it will include this address. **Physical**

What is your Primary Specialty? (If None Please Choose None) **Obstetrics & Gynecology**

Is your Primary Specialty Board Certified? **Yes**

What is your Secondary Specialty? (If None Please Choose None) **None**

What is the name of the Primary Hospital where you have staff privileges? **Boston Medical Center**

What City is the Primary Hospital where you have staff privileges located? **Boston**

What State is the Primary Hospital where you have staff privileges located? **Massachusetts**

Are you licensed in another state? **Yes**

Which Ones? **Massachusetts**

Are you actively engaged in clinical practice in the State of Alabama? **Yes**

What is your principal county of practice? (If principal county is not in Alabama choose Out of State) **Out of State**

Other counties of practice? Type "None" if you only practice in the indicated principal county. **suffolk**

Do you currently perform/offer to perform any office based surgery/procedure which requires 1) moderate sedation, deep sedation, or general anesthesia; 2) liposuction when infiltration methods such as the tumescent technique are used; or 3) any procedure in which propofol is administered, given or used? **No**

Primary Care Information - Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

Does your practice included the delivery of primary care or mental health services (OB/GYN, general medicine, family medicine, general pediatrics, general internal medicine, general psychiatry or child psychiatry)? **Yes**

Approximately how many hours per week do you perform direct patient care in your office, involving the above defined primary care or mental health services in Alabama? **8**

Approximately how many patient office visits per week do you have involving the above defined primary care or mental health services in Alabama? **8**

CME Certification: (Select One) **I hereby certify that I have met or will meet by December 31 the annual minimum continuing education requirement of 25 hours of AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2014 and have or will have supporting documentation if audited.**

Please answer the following questions.

Have you been charged with a criminal offense (felony/misdemeanor) within the past year? **No**

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered while under investigation, or threat of suspension or revocation within the past year? **No**

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice or voluntary surrendered within the past year? **No**

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate or qualification or license to practice medicine been withdrawn under threat of denial within the past year? **No**

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **No**

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **No**

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **No**

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **No**

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **No**

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or for any sexual boundary violation? **No**

Have you engaged in the unauthorized use of controlled substances with the past twelve months? **No**

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **No**

Within the past year has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation or maternity leave? **No**

By agreeing with this data, you are signing this registration form and attesting that the material has been supplied by you, the licensee, and that all information is correct. Knowingly providing false registration information to the Alabama Medical Licensure Commission may result in the loss of your license to practice medicine.



Medical Licensure Commission of the State of Alabama
PO Box 887
Montgomery, AL 36101

2016 Online Renewal Summary

Name: **Sacheen Carr Ellis null**

License Number: **MD.33448**

Transaction Date: **2015-11-05***

Transaction Number: **AU3EDB9CD2F1**

Registration Fee: **300**

Date of Birth: **1973-04-02**

* - This date reflects the date that the transaction was downloaded into the production system not the date the transaction was processed online.

FAILURE TO RENEW THIS LICENSE TO PRACTICE MEDICINE OR OSTEOPATHY BY JANUARY 31 WILL RESULT IN LICENSE BECOMING INACTIVE WITHOUT FURTHER NOTICE.

Under Alabama law, this document is a public record and if requested it will be provided in its entirety.

Mailing Address (For Official Correspondence Only)

Street **210 LINCOLN ST**

Apt/Suite **APT 503**

City **BOSTON**

State **Massachusetts**

Zip **02111**

County (If not in Alabama Choose 'Out of State' **Out of State**)

Country **United States**

What is your current status? **Active**

Physical Home Address (No PO Box)

Street **210 LINCOLN ST**

Apt/Suite **APT 503**

City **BOSTON**

State **Massachusetts**

Zip **02111**

County (If not in Alabama Choose 'Out of State' **Out of State**)

Country **United States**

Home Phone? **617-519-4323**

Home Email? **Scarrellis@gmail.com**

What is your Primary Specialty? (If None Please Choose None) **Obstetrics & Gynecology**

Is your Primary Specialty Board Certified? **Yes**

What is your Secondary Specialty? (If None Please Choose None) **None**

Are you licensed in another state? **Yes**

If yes which other states are you licensed? **Maryland Massachusetts Mississippi**

Please designate a "PUBLIC" address. The public address will be the address given out if an address is requested. **Practice/Work Address**

CME Certification

CME Certification: (Select One) **I hereby certify that I have met or will meet by December 31 the annual minimum continuing education requirement of 25 AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 2015 and have or will have supporting documentation if audited.**

Practice Information

Physical Practice/Work Address (No PO Box)

Street **717 DOWNTOWNER LOOP W**

City **MOBILE**

State **Alabama**

Zip **36609**

County (If not in Alabama Choose 'Out of State' **Mobile**)

Country **United States**

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Practice/Work Telephone? **866-865-7748**

The Medical Licensure Commission (MLC) and the Alabama Department of Public Health (ADPH) are requesting a valid email address on each physician for the purpose of sending official license information and appropriate Health Alert Network (HAN) messages. The purpose of a HAN is to share urgent public health information about emerging situations. Email addresses will not be sold or disseminated for any other purpose.

Practice/Work Email? **Sacheen.ellis@ppse.org**

What is the name of the Primary Hospital where you have staff privileges? **Boston Medical Center**

What City is the Primary Hospital where you have staff privileges located? **Boston**

What State is the Primary Hospital where you have staff privileges located? **Massachusetts**

Are you actively engaged in clinical practice in the State of Alabama? **Yes**

What is your principal county of practice? (If principal county is not in Alabama choose Out of State) **Mobile**

Other counties of practice? Type "None" if you only practice in the indicated principal county. **Birmingham**

Do you currently perform/offer to perform any office based surgery/procedure which requires 1) moderate sedation, deep sedation, or general anesthesia; 2) liposuction when infiltration methods such as the tumescent technique are used; or 3) any procedure in which Propofol is administered, given or used? **No**

Primary Care Information

Primary care is defined as: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system, exclusive of an emergency situation.

Does your practice include the delivery of primary care or mental health services (OB/GYN, general medicine, family medicine, general pediatrics, general internal medicine, general psychiatry or child psychiatry)? **Yes**

Approximately how many hours per week do you perform direct patient care in your office, involving the above defined primary care or mental health services in Alabama? **10**

Approximately how many patient office visits per week do you have involving the above defined primary care or mental health services in Alabama? **10**

Professional Responsibility Certification

Have you been charged with a criminal offense (felony/misdemeanor) within the past year? **No**

Has your certificate of qualification or license to practice medicine in any state been suspended, revoked, restricted, curtailed or voluntarily surrendered while under investigation, or threat of suspension or revocation within the past year? **No**

Have your staff privileges at any hospital or health care facility been revoked, suspended, curtailed, limited or placed under conditions restricting your practice or voluntarily surrendered within the past year? **No**

Have you been denied a certificate of qualification or license to practice medicine in any state or has your application for a certificate of qualification or license to practice medicine been withdrawn under threat of denial within the past year? **No**

Have you had a judgment rendered against you, or action settled relating to the performance of your professional service within the past year? **No**

To your knowledge, are you the subject of an investigation, or has a formal complaint against your license been filed by any licensing Board/Agency as of the date of this application within the past year? **No**

Within the past year, have you been diagnosed with or have you been treated for bi-polar disorder, schizophrenia, paranoia, or any other psychotic disorder? **No**

Do you currently have any mental or physical condition or impairment (including, but not limited to, substance abuse, alcohol abuse, or mental, emotional, or nervous disorder or condition) which in any way currently affects, or if untreated could affect, your ability to practice in a competent and professional manner or, within the past year, have you applied for and/or have you received any payment or other compensation for any mental or physical condition? **No**

The term "currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as a physician, or within the past two years.

Within the past year, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution, employer, government agency, professional organization or licensing authority? **No**

Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or for any sexual boundary violation? **No**

Have you engaged in the unauthorized use of controlled substances within the past twelve months? **No**

Are you currently participating in the Alabama Physician's Health Program or any supervised rehabilitation program which monitors you in order to assure that you are not engaging in the unauthorized use of controlled substances or alcohol? **No**

Have you been, within the past year, convicted of driving under the influence (DUI) or have you been charged with DUI and been convicted of a lesser offense such as reckless driving? **No**

Within the past year has your medical training or medical practice been interrupted or suspended for a period longer than 60 days for any reason other than a vacation or maternity leave? **No**

By agreeing with this data, you are signing this registration form and attesting that the material has been supplied by you, the licensee, and that all information is correct. Knowingly providing false registration information to the Alabama Medical Licensure Commission may result in the loss of your license to practice medicine.