

## 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, <u>please read the instruction booklet</u>. 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 <u>green</u> envelope <u>4 weeks</u> before your renewal date.

- · Remit \$250.00 for renewal fee.
- · Add late fee of \$25.00, if necessary.

- · Return renewal application in GREEN envelope.
- · Enclose check with coupon in BLUE envelope.

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

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I. Current Status: Active Registration	•
	ne 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 Oct - Name (a) if any under which you were lineared	Please make corrections (type or print)
2. Other Name(s), if any, under which you were licensed:	Other Name(s):
The state of the s	\
3. A) Mailing/Business Address: NICHOLAS PANTELAKIS	Mailing Address: State:
6 ESSEX CENTER DRIVE	
NICHOLAS PANTELAKIS 6 ESSEX CENTER DRIVE SUITE 201 PEABODY, MA 01960-2910	Zip: Country:
PEABOD1, MA 01900-2910	Business Address:
B) Home Address:	City/Town: State:
In East	Zip: Country: Business Telephone: ()
\%	
\\\\\\\\	Home Address: City/Town: State: Zip: Country:
Home Phone:	Zip: Country:
	Home Telephone: ()
Business Phone:	PLEASE NOTE: No P.O. Box addresses for home or business addresses.
4. a) Date of Birth: b) Sex: M	7. Current American Board of Medical Specialties Certification (See Tab Code: Code:
c) SS#:	G. David Lieuwa Niumbara if muu
5. a) Name of Medical School;	8. Drug License Numbers, if any: a) Federal (DEA):
	b) Massachusetts:
Boston University School of Medicine b) Year Graduated: 1970 c) Degree: M.D.	9. a) Other states where you are now licensed to practice (Abbr.)
6. Specialty Code(s) (See Table 1)	b) States where you were previously licensed (Abbr.)
Code(s) Hours per Week in Mass.	b) States where you were previously measure (11001.)
OBG 0 Obstetrics and Gynecology	
0. Current health care facilities at which you have complet	ted the credentialing process for the provision of patient care. (Supply those health care facilities where you have admitting privileges (AP), of patient care hours that you provide in each facility).
acility Code: \$ 58/1/(AP) 98 % Facility Code:	999/ (AP) 2 % Facility Code: / (AP) %
cility Code: / (AP) % Facility Code:	9.99/ (AP) 9 % Facility Code: / (AP) % / (AP) % Facility Code: / (AP) %
999, print name(s): Beverly Hospital	

P	RINT YOUR LAST NAME: PANTELAKIS LICENSE NUMBER: 33	413	
11.	My medical malpractice insurance is covered by a) M Insurance Carrier b) Letter of Credit  Name of Insurer: Alternatively, indicate as follows:		
a)	m 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 b)  Otherwise exempt ease explain exemption:		
	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one)  A. What is your principal work setting? (See Table 4)	Yes	M
	B. Care of patients in Massachusetts (see instruction booklet).  1) Average weekly hours involved in:  a) outpatient care 40 hrs/wk b) inpatient care 8 hrs/w	k	
	2) What is the approximate percentage of your patient care hours in primary care? 45%  ART A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS	_	
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each questi ails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional info initions. You must answer ALL questions, or this form will be returned to you and your license renewal may	rmatio	n and
		YES	NO
14.	<u>CLAIMS MADE</u> : 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?		
	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?		
	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?		
	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
	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 ☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME	E exemp	No tion
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applications	tion.	
	suant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule a		
	suant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and pai sachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you reside out-of-state or out of the United		
•	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 r withholding and remitting Child Support.	elating i	to
•	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, § 5	IA.	
•	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R	s true.	
Sigr	nature: Micholas Jantelakie, M.D. Date: 1	131	0/

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.

#### **BOARD OF REGISTRATION IN MEDICINE** IMPORTANT -- READ, COMPLETE AND SIGN --SEE REVERSE SIDE 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 HEQUIRED UNDER LAW ROOM 1507 - 100 CAMBRIDGE STREET YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BOSTON, MASSACHUSETTS 02202 ON THE REVERSE SIDE OF THIS APPLICATION. (SEE RENEWAL APPLICATION 1986-1988 THE ENCLOSED INSTRUCTIONS FOR DETAILS.) SOC SEC NO. OPTIONAL IF YOU ANSWERED "YES" TO ANY OF THESE GUES-TIONS, YOU MUST CHECK THIS BOX: YOU MUST SIGN BELOV PLEASE USE THE ENCLOSED RETURN ENVELOPE LICENSE NUMBER THIS APPLICATION MUST BE SIGNED AND PAY THIS DATÉ TO BE BENEWED NOTE! RETURNED WITH A \$100 PAYMENT. A CERTIFIED CHECK OH MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE FEE LATE FEE THUOMA CODE 1719 BEGISTRATION NO MO ()A MD 33413 100.00 100.00 01 15 86 PAYABLE TO: PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW COMMONWEALTH OF MASSACHUSETTS NICHOLAS PANTELAKIS P.O BOX 6 NORTH SHORE MED PK BOSTON, MASSACHUSETTS 02297

DO NOT WRITE BELOW THIS LINE

ESSEX CENTER DR

MA 01960

PEABODY

3500600334136 011586 10000000004

Fint Name Nicholas P	ANTELAKIS	Date of Bath	•	
Medical State Boston U You must read the in-leaching enclosed with the				
1. Pancipal Spacialty(iPs). OBSTET	rics - Gyne cology	2. Principal work setting	OFFICE -	HOSPITAL
3. Home address:	ŕ	4. Principal husiness addre	ss ESSCX Ceni	Ter Drike
5. I list all hospitals at which you have currently	offective privileges. HANT MEN	norial (DANVers)	J.J.B. Thenas	(Peabody)
B. blates other than Massachusetts in which	you are lecensed to practice			
N. Have you been a defendant in any malpractic     B. Have you been a defendant in any cruminal p.     Has any deceptionry action been taken again     professional medica, association (internation)	roceeding other than minor traffic offenses co	ommenced since 100/83?	30 tulb ategris 30 tulb ategris 30 tulb ategris hoalth care facility, or by any	YI:\$ NO
10. Har your privilege to possess, dispense or pr	escribe controlled substances ever been sust	pended or revoked in this state of	rany other?	ا
H. I have completed by C.M.L. requirements be 12. Lancab active inactive 1. THRUBY CHRIBY UNDER THE PLNALTY (YOU MUST ALSO SIGN THE FRONT OF THIS	practitioner (Check one) OF PERJURY THAT THE ABOVE INFOR	$\mathcal{M}_{\mathcal{I}}$	cholas Plate	Labor Wal
				,

DIVISION OF REGISTRATION HOOM 1520 - 100 CAMBRIDGE STREE BOSTON, MASSACHUSETTS 02202 100 CAMBRIDGE STREET 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 STAYE TAX RETURNS AND PAID ALL STATE TAXES

REQUIRED UNDER LAW.

SOC SEL NO DR FEDERAL IO NO YOU MUST SIGN BELOW x Michaelas

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 Cantelake AND TATUTES AND/OR RULES AND

MY SIGNATURE ON THE THEOREM

REGULATIONS.

CODE	LICEN	SE NUMBER REGISTRATION NO	PAY THIS AMOUNT	FEE		ATURE I BI- REN UA		LATE FEE	•
MD		33413	100.00	100.00	01	15	84		
κŽ	L	h	<b></b>	PLE	ASE PRIN	T ANY N	AME OF	ADDRESS	

PLEASE USE THE ENCLOSED RETURN ENVELOPE THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A CERTIFIED CHECK OR MONEY ORDER — PAYABLE TO: Note

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

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

DO NOT WRITE BELOW THIS LINE

NORTH SHORE MED PK ESSEX CENTER DR PEABODY MA 01960

NICHOLAS PANTELAKIS

3500600334136 011584 10000000009

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#### 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. · Return renewal application in GREEN envelope, · Remit \$250.00 for renewal fee. • Enclose check with coupon in BLUE envelope · Add late fee of \$25.00, if necessary. Registration No.: 33413 Renewal Date: 03/09/1999 1. Current Status: If you want to change your current status, please indicate below: (Check one). Active Retiring (see instructions) Inactive (see below \*) Do not paish to renew Please make corrections (type or print) 2. Other Name(s), if any, under which you were licensed: Other Name(s): 3. A) Mailing/Business Address: Mailing Address: NICHOLAS PANTELAKIS, M.D. State: City/Town: 6 ESSEX CENTER DRIVE Zip: \_\_\_\_\_ Country: \_\_\_\_\_ SUITE 201 PEABODY, MA 01960-2910 B) Home Address: Other Address: City/Town: Zip: Country: Home Phone: Home: ( Business Phone: (978) 531-4848 Business: ( Date of Birth: (M/D/Y): \_\_/\_ / \_ Sex : \_ M \_ F 4. A) Date of Birth: Sex: M SS#: [ B) SS#: Full Name of Medical School: 5. A) Name of Medical School: Boston University School of Medicine B) Year Graduated: 1970 C) Degree: MD Year Graduated: Degree: M.D. D.O. 6. Specialty Code(s) (See Table 1) Code(s) Hours Per Week in Massachusetts Code(s) Hours per Week in Mass. OBG 52 Obstetrics and Gynecology If OS, Print Specialty: 7. Current American Board of Medical Specialties Certification (See Table 2) Code: Code: Code: Code: 8. Drug License Numbers, if any: Federal (DEA): A) Federal (DEA): Mass: B) Massachusetts: 9. A) Other states where you are now licensed to practice B) States where you previously were licensed to practice

Abbr:

Abbr:

<sup>\*</sup>If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.

PI	RINT NAME AND NUMBER: Last Name: PANTELAKIS Registration Number:	3 <i>3413</i>	
the	Current health care facilities at which you have completed the credentialing process for the provision of patient care codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges ch facility, write the approximate percentage of patient care hours that you provide in each facility.		i tç
Fa	cility Code: 0.58/V (AP) 48 % Facility Code: / (AP) % Facility Code: / (AP)	AP)	%
Fa	cility Code: 0 07/ (AP) 2 % Facility Code: / (AP) % Facility Code: / (	AP)	9
lf	999, print name(s): ABS Tusurmet hoviers towner towners towner from the Cosustin	e. The	
	My medical malpractice insurance is covered by a) X Insurance Carrier b)  Letter of Credit		
	Name of Insurer: LAWRENCOVILLE Property & (acost Alternatively, indicate as follows:		
la	m 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 b)  Otherwise exempt		
•	ase explain exemption:		
	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one)	☐ Yes 🏻	N
	A. What is your principal work setting? (See Table 4) 1 5		
	B. Care of patients in Massachusetts (see instruction booklet).		
	1) Average weekly hours involved in:  a) outpatient care 2 hrs/wk b) inpatient care 25 hrs/w	k	
	2) What is the approximate percentage of your patient care hours in primary care? 3.5 %		
D A	RT A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
		10).f	_
let	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each questi- alls on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional info initions. You must answer ALL questions, or this form will be returned to you and your license renewal may	rmation ar	ıd
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	CT A BAC BY A DE. Has any medical malaractics claim hear made avainst you that has not yet been finally	1ES I	Y
	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?		
6.	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?		
8.	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?		
12	CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date?   Yes	∏ No	,
.2.	CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) Training Progr		
			ΔH
see	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applications for CME. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee sched		
•			
•	Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns an Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the U	Inited States	١.
•	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,		
	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R	s true.	
Sig	nature: Michelas Fantelalais, M. S. Date: 1	12919	2

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION



#### 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

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· 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. · Return renewal application in GREEN envelope. · Add late fee of \$25.00, if necessary. · Enclose check with coupon in BLUE envelope. Registration No.: 33413 03/09/97 Renewal Date: Active 1. Activity Status: Retiring (see instructions) (Check only one) ☐ Inactive \*(see below) Do not wish to renew 2. Other Name(s), if any, under which you were licensed: Corrections (type or print) Other Name(s): AMailing/Business Address: NICHOLAS PANTELAKIS, M.D. Mailing Address: 6 ESSEX CENTER DR City/Town: State: SUITE 201 PEABODY, MA 01960-2910 Zip: \_\_\_\_\_ Country:\_\_\_ R)Home Address: Other Address: City/Town: \_\_\_\_\_ Zip: \_\_\_\_\_Country: \_\_\_\_ Home: (\_\_\_\_)\_\_\_\_ Home Phone: Business Phone: (508) 531-4848 Business: (\_\_\_\_) Date of Birth (M/D/Y): \_\_\_/\_\_/ Sex (M/F): \_\_\_\_\_ 4. A) Date of Birth: C) Sex: M Lic. Issue Date (M/D/Y): / / SS#: B) Lic. Issue Date: 07/15/71 D) SS#: Full Name of Medical School: 5. A) Name of Medical School: Boston University School of Medicine Year Graduated: \_\_\_\_\_ Degree (MD/DO): B) Year Graduated: 70 C) Degree: MD 6. Specialty Code(s) (See Table 1) Code(s) Hours Per Week in Mass. Code(s) Hours per Week in Mass. OBG Obstetrics and Gynecology If OS, Print Specialty: 7. Current American Board of Medical Specialties Certification (See Table 2) Code: Code: 8. Drug License Numbers, if any: Federal (DEA): A) Federal (DEA): B) Massachusetts: 9. A) Other states where you are now licensed to practice

B) States where you previously were licensed to practice

Abbr:



<sup>\*</sup>If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts

Pl	RINT NAME AND NUMBER: Last Name: PANTELAKIS, Nichelas Registration Number:	33	413
10	A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Sur Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).  Facility Code:	ply the co	des trom
	B. Additional health care facilities at which you previously held privileges or with which you were associated in the past (See Table 3)		
	Facility Code: Facili	A. M. MAT	
11.	My medical malpractice insurance is covered by a)Insurance Carrierb) Letter of Credit		
	Name of Insurer: Medical Professional Mutual Insurance Company		
	Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insura	ned bacon	Dr.A
	l am (check one) a) Not involved in direct/indirect patient care in Massachusetts h) Otherwise exempt  Please explain exemption:	arce ocean	Si.
12.	Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow? (check one)	voe krad	
	A. What is your principal work setting? (See Table 4) 1 5	1 C.S. [8]	140
	B. Care of patients in Massachusetts (see instruction booklet).		
	1) Average weekly hours involved in:  a) outpatient care 35 hrs/wk b) inpatient care / 7 hrs/w	Ь	
	2) What is the approximate percentage of your patient care hours in primary care? 50 %	κ.	
n			
	ART A		
<u>det</u>	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each que ails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in initions.	stion. Pr Iformatic	ovide on and
IN	THE PAST TWO (2) YEARS:	YES	NO
14.	<u>CLAIMS MADE</u> : 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.	<u>CLAIMS RESOLVED:</u> 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?		
	Have you been charged with any criminal offense, other than a minor traffic violation?		
	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?		
	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?		
	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		Ì
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	L	1
Sec	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 ANS	WERED	
	nature Meshola, Toutelalois M. Date: 3/3	9.90	2

### 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           33413         ACTIVE         \$250.00         03/09/95         \$25.00	Correction of Mailing Address						
Mailing Address: NICHOLAS PANTELAKIS, M.D. 6 ESSEX CENTER DRIVE SUITE 201 PEABODY, MA 01960	Address (Mailing):  City/Town: State: Country:						
Directions: Before proceeding, please read the instruction booklet. Some q	uestions are optional.						
<ul> <li>Failure to renew in a timely manner will cause your license to lapse an ability to practice medicine in the Commonwealth. (See enclosed letter)</li> </ul>	nd may affect your Roy Office Design (1997).						
· 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	Corrections of Pre-Printed Information						
1. Other name(s), if any, under which you were licensed:	Name:						
2 Home Address:	Address:						
	City/Town: State: Zip: Country:						
3. Date of Birth: Sex: M Lic, Issue Date: 07/15/71 SS#:	Date of Birth (M/D/Y): Sex (M/F): Lic. Issue Date (M/D/Y): SS#:						
Home Phone Business Phone (508) 531-4848	Home: ( ) Business: ( )  Pull Name of Medical School:						
4. Name of Medical School: Boston University School of Medicine							
Year Graduated: 70 Degree: MD	Year Graduated: Degree (MD/DO):						
<ul><li>5. a) Other states where you are now licensed to practice (Abbr):</li><li>b) States where you previously were licensed to practice (Abbr):</li></ul>							
6. Specialty Code(s) (See Table 1):  Code Hours per Week in Mass.	Code Hours per Week in Mass.						
OBG 52 Obstetrics and Gynecology	If OS, print specialty:						
7. If you are currently American Specialty Board certified, enter codes: (S	ee Table 2)						
Code: Code:	Code:						
8. Drug license number(s), if any:  a) Federal (DEA) b) Massachusetts	Federal (DEA):Mass:						
9. Activity Status: I am applying to be registered with the following statu	s: 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: PANTELOKIS Registration Number: 3341	3
10. a) Current health care facility(ics) 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: /	
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 ye (See Table 3)	
Facility Code: Facility Cod	
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, check one.  List Insurer: M3553 chu 5 etts Medic of Professional Tasurance Association	
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:  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) 15	
b) Care of patients in Massachusetts (See instruction booklet.)  i) How many hours per typical week are you currently involved in outpatient care in Mass?  ii) How many hours per typical week are you currently involved in inpatient care in Mass?  c) Approximately what percentage of your patient care hours are in primary care?  (See instructions for definition of primary care.)	
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.	
	Q
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?	
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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.	
<ul> <li>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</li> </ul>	
<ul> <li>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 beline filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies</li> </ul>	ef,
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: Micholan Jantelakis, M. D. Date: 211,95	

#### 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           53413         ACTIVE         \$250.00         03/09/93         \$25.00	1	Correction of Mailing Address:
_	Mailing Address: NICHOLAS PANTELAKIS, M.D. 026 SALEM STREET LYNNFIELD, MA U1940	City/Town: State:	able 1):
• !	rections: Staple check to bottom of form. Add late fee if necessary Questions 1-8 include information from Board files. Please correct as ne provided on the right hand side of the page. Before proceeding, please read the instruction booklet. Some questions a Make a copy of this form and all attachments for your own records for credentialing and other purposes. The Board will charge a fee for ea Enclose the \$250.00 renewal fee by means of a certified check, money or payable to the Commonwealth of Massachusetts.	cessary in the boxes are optional. you will need copies uch copy it provides, rder or personal check r	
Pr	e-Printed Information	Correct	tions of Pre-Printed Information
	Other name(s), if any, under which you were licensed:  a) Address (Home):	Address (Home): City/Town: State:	Zip:
	b) Address (Business):  525 SALEM STREET  LYNNFIELD, MA 01940	Address (Business):	If 999 print Country:  If 999 print Country:
	Date of Birth: Sex: [4] Lic. Issue Date: 07/15/71 SS#: Telephone Number:  Home Business (617) 592-0123	Lic. Issue Date (M/D/ Telephone Number: Home: ( )	Sex (M/F):  SS#:  Business: ( )
4.	Name of Medical School:  Doston University School of Medicine  Year Graduated: 70 Degree: MD	Year Graduated:	Degree (MD/DO):
	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.  3.36 52 Obstetrics and Gynecology	If OS, print specialty	Hours per Week in Mass.
7.	a) If you are currently American Specialty Board Certified, enter Codes:  Code:  Code:	-	Code:
	<ul> <li>b) If you previously were American Specialty Board certified, but are not please enter codes of prior certification: (See Table 3)</li> <li>Code: Code:</li> </ul>	longer,	Code:
8.	Drug License Number(s), if any:  a) Federal (DEA)  b) State (MA)		Federal (DEA): State (MA):
	I have completed my CME requirements in the two years preceding my You must fill out a separate Waiver Form. The waiver must be granted CME requirements. Do not submit documentation of your CMEs with y	hy the Board before you	No, waiver requested are license will be renewed. See instructions for h. Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: [ANICLAMS Registration Number: 33973
PRINT NAME AND NUMBER: Physician Last Name: AUCLAIMS Registration Number: >>7(5)
10. Activity Status: I am applying to be registered with the following status: Active Inactive
I hereby certify that if requesting fractive status, I will not practice raedicine, 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:
List Insurer:  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: 7 / (AP) Facility Code: 7 / (AP) Facility Code: (AP)
Facility Code: 93/2(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: Facil
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)
b) Care of patients in Massachusetts (MA) (See instruction booklet.)  i) How many hours per typical week are you currently involved in <i>outpatient</i> care in MA? And hrs/wk in MA  ii) How many hours per typical week are you currently involved in <i>inpatient</i> care in MA? And hrs/wk in MA
Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT M/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:
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was file: 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 et a denied a medical license for any reason?
20. Have you had any mental illness which has impaired you abile, 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, tenninated or imposed a surcharge on your coverage?
Pursuant to G.L. c. 112, sec. 2, I will not cause 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.I., c. 119, sec. 51A.
· I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.
Signature: Michala Verilelaka Mit. Date: 1127193



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

Registration No.	Status	Fee	Renewal Date				For Office Use Only	
33413	ACTIVE	\$150	03/09/91				M.R.	01.72.00
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	PEAU OD Y > - M	A U196	0=		13147	5167		
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. Answer all non-c	optional questions co	ompletely. (	The instructions specify	y which	nuestions are opti	onal.)	12/ W	
			r your own recordsyou	must g	ive health cline lac	allithes adopieu	e fooredentialing purpos	es. The Board charges
\$3.00 plus posts	ge for each copy fur	mished.	andition shook manay	وأأم	LI Callet		lere the Commonwealth	of Managahuantta
Activity Status:	o.oo ranawai iee by	IIIdaiis Oi a	Columbo Greek, morey	Ologi o	(C) (I)	days bayao	A.	A Wassachinsons.
am applying to be	registered with the certify that if requ	following streaming in ac	atus: Active kill not p	oractice	medicina in Medicina	President		
Pre-Printed Inform	nation				Corrections of P	re-Printed I	information	
1. Other Name(s)	), if any, under which	h you were l	icensed:	Nam	e: Dv. N,	cholo	S PANTOLA	ris
2. a) Address (Horr	10):				ess:			
					Town_		Zip:	
				Cour	to Code:	/if 000 u	/rite Country):	
2. b) Address (Busi	iness).						M ST	
	DRE MED PK			City/	Town LYN,	NEGAL	5. <b>b</b>	-
	ITER DRIVE			State	Ma	ر ح	Zip:	01940
	MA 01960-			Coun	try Code: O	(if 999, v	vilte Country):	
3. Date of Birth:		Sex: M		L	Date of Birth (M/I	D/Y):		Sex (M/F):
	07/15/71			i			// SSN #:_	
Telephone Nur								
<u>Home</u>		Business			Home: ()_		Business: (617)	592-0193
			531-6666					
<ol> <li>Medical School Name of School</li> </ol>		Year Grad	luated: 70 Degree:	MD			ar Graduated: 1	
			ol of Medic	ine		T	<u> </u>	
	where you are now li you previously were							
6. Specialty Code	n(s) (See Table 3):				r m. electric estal quanti quanti qua esta esta esta esta esta esta esta est	L		
Code	Hours per Week in	Mass.			Code		Hours per Week in Mas	8.
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000	0	, , , , ,		••••				
	•				If OS, write spec	cialty:		
7.a) Are vou Ameri	ican Specialty Board	d Certified?	(Y/N) N 7.b) If YE	es, Ent	er Codes:	ľ		
Code:	. ,					Code:		
Code:						Code:	···	
						L		
8. Drug License N	Number(s) (if any) In	ofionall: a) i	Federal (DEA)				b) How many DEA nos.	do vou have?
g			State (MA) #M				y	,
0 I hours comets	tod my C ME word	iromante in 1	the two years eropedies	n noveres	awal deta	YES 🗸	Mais	er Requested
			the two years preceding e waiver must be grant					
			of your CME's with you					
30M - 9/90 - P81397	<b>'</b> 1				[ For Office Use	Only: Waiv	er Granted Date	:/]

FII	I. IN NAME AND NUMBER: Physician Last Name: PANTOLAKIS Registration No.: 33413
10.	My medical malpractico insuranco is covorod by (a) INSURANCE CARRIER (or (b) LETTER OF CREDIT, If applicable, check one.
	List Insuror:  Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one):  (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:  (ii) OTHERWISE EXEMPT:
	(State how otherwise exampt):
11.	Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).
	Facility Code: 58 / (AP) Facility Code: 7 / (AP) Facility Code: / (AP)
	Facility Codo: 1711(AP) Facility Code: / (AP) Facility Code: / (AP)
	ff 999, write Name(s):
	Additional Hospitals at which you <u>previously</u> held privileges and other Health Care Facilities with which you were associated in the past 4 years. (See Table 5.)
	Facility Code: Facili
	If 999, write Name(s).
12.	Post Graduate Training in Massachusetts (MA) (Soe instruction booklet.)  a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes No (Check one.)  b) If you are in a MA program, are you a i) Resident ii) Clinical Fellow or iii) Research Follow? (Check one.)  c) How many hours per typical week do you spend in this MA post-graduate training program? hrs./wk. In MA.
13.	Care of Patients in Massachusetts (MA) (See instruction booklet.)  a) How many hours per typical week are you currently involved in <i>outpatient</i> care in MA? 53 hrs./wk. in MA.  b) How many hours per typical week are you currently involved in <i>inpatient</i> care in MA? 5 hrs./wk. in MA.
14.	Principal Work Setting.  a) What is your principal work setting? (See Tuble 6) $\pm 5$
	estions 15 through 22 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.  By to the instruction booklet for additional information.
15. [	Yes No Has any pending or now modical malpractico claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
	Have you been a detendant 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 regulationsSee Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?
18, k	Has your privilege to possess, dispense or prescribe controlled substances been suspended, rovoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?
19. 1	Have you withdrawn an application for a medical license or been denied a modical license for any reason?
20. I	Have you had any mental illness which has impaired your ability to practice modicine or to function as a student of medicine?
21. F	Have you had an organic illness which has impaired your ability to practice modicine or to function as a student of medicine?
22. /	Are you now, or have you been in the past four years, dependent upon alcohol or drugs?
Pure	suant 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.
tax ı	suant 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 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 ntry.
cor	tify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L. c.119 sec.51A.
her	reby certify under the pensities of perjury that all information on this form and Form 15A is true.
Sign	ature: Michola Cantelabi M. 8 Date 1,22,91

#### I. PHYSICIAN INFORMATION

Make changes to name here  Mass License \$\ 38413 \ License Status \ Active \ Hospital Affiliation  6 Essex Center Dr.	NICHOLAS First Name	Middle mitial		PANTELAKIS  Last Name		
Mass License # 38413 First Issue Date 07/15/71 License Status Active  Hospital Affiliation  8 Essex Center Dr. Melrose-Wakefield Hospital Hunt Memorial Hospital Beverly Hospital Hunt Memorial Hospital Beverly H					Suffix	
Hospital Affiliation	Make changes to name here					
8 Essex Center Dr. Suite 201 Peabody, MA 01960-2910 U.S.A. (508) 531-4348  Make address corrections here:    Make and corrections to above here.				First Issue Date	07/15/71	
Suite 201 Peabody, MA 01960-2910 U.S.A. (508) 531-4348  Make address corrections here:  Make any corrections to above here:  Make any corrections to above here:  Make any corrections to above here:  Licenses Held in Other States:  The Ts. resuth flower  Bittle Cross. Dive Sheld  Missing Cross. Dive Sheld  Make any corrections to above here:  Accepting New Patients? Myes Cross. Diversify Cr			Hospital Affiliation			
Insurance Plan Affiliation:  Licenses Held in Other States:  Accepting New Patients? Xyes Career as necessary.  Accepting New Patients? Xyes Career as necessary.  Accept Medicaid? Xiyes Career as neces	Suite 201 Peabody, MA 01960-2910 U.S.A.		Hunt Memorial Hospita			
Accepting New Patients? Ayes [Pi.L.6 r.m.]  Believe Cr. 0.5 S - Deue Streets  W. S. 176 2 LTH Core  W. S. 176 2 LTH Core  Fring Per Heaving Core System  (Please correct as necessary)  Accept Medicaid? Ayes [Please correct as necessary)  Accept Medicaid? Ayes [Please correct as necessary]  Accept Medicaid. Ayes [Please correct as necessary]  Accept	Make address corrections he	re: Muke	any corrections to above	here:		
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Accepting New Patients? Ayes [Pi.L.6 r.m.]  Believe Cr. 0.5 S - Deue Streets  W. S. 176 2 LTH Core  W. S. 176 2 LTH Core  Fring Per Heaving Core System  (Please correct as necessary)  Accept Medicaid? Ayes [Please correct as necessary)  Accept Medicaid? Ayes [Please correct as necessary]  Accept Medicaid. Ayes [Please correct as necessary]  Accept	N 4071			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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Boston University School of Medicine  MD 70  Medical School  Degree Date  MAD 70  Degree Date  Make corrections here  Both Isrape Hosp. Boston Taly 1971  Start  End  esidency Program(s)  Start  End  esidency Program(s)  Start  End  Start  End  Start  End  Start  End  Start  End  Certifying Board Name:  condary Specialty:  Certifying Board Name:	Private Health	Cove cove System (Ple	ase correct as necessary)	Accept Medicaid;	XIYES   No	
ledical School  Degree  Date  Aske corrections here  BETH ISRBEL HOSP. BOSTON TULY 1971  Fesidency Program(s)  End  Esidency Program(s)  Start  End  Esidency Program(s)  Start  End  Esidency Program(s)  Start  End  End  End  Start  End  Cestidency Program(s)  Certifying Board Name:  Condary Specialty:  Certifying Board Name:	•	NING				
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ake any corrections here: Make any corrections here:	ake any corrections here:		Make any correcti	ons here:		
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Final Decisions and orders issued by the Ma		
•	assachusetts Board of Registration	in Medicine.
Nature	<u>Date</u>	Board Action
HOSPITAL DISCIPLINE		
<u>Hospital</u>	<u>Date</u>	Disciplinary Action
CRIMINAL CONVICTIONS  The Board of Registration is unable to obtain	a accurate data for this category a	t the present time. This information will be
included when the court system is fully composed complaint	outerized. Please list any crimina	l convictions. Include conviction date and nature
MALPRACTICE  Details of claims paid for Dr. PANTELAK	us	No. of Years in Practice: # 2 /
Date Amount Paid Date Amount Paid Date Amount Paid	Basis for Basis for Basis for Basis for Basis for	Complaint Complaint Complaint Complaint Complaint Complaint Complaint
	VIEWED BUDITONS	
PHYSICIAN HONORS & PEER-REV Please enter any peer-reviewed publications professional recognition you have been given	to which you have contributed an	d any awards for community service or
Please enter any peer-reviewed publications professional recognition you have been given Awards, Honors	to which you have contributed an	Publications  1 CL Rose - WAKEFIELD 140-9
-	CRIMINAL CONVICTIONS The Board of Registration is unable to obtain included when the court system is fully compof complaint  MALPRACTICE Details of claims paid for Dr. PANTELAK Date Amount Paid 0.0 Date Amount Paid	CRIMINAL CONVICTIONS  The Board of Registration is unable to obtain accurate data for this category a included when the court system is fully computerized. Please list any crimina of complaint  MALPRACTICE  Details of claims paid for Dr. PANTELAKIS  Date Amount Paid 0.0000 Basis for Date Amount Paid Basis for Date Basis for Date Amount Paid Basis for Date Amount Paid Basis for Date Amount Paid Basis for Date Basis fo

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

#### **BOARD OF REGISTRATION IN MEDICINE**

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

SOC SEC. NUMBER, OPTIONAL		-		
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	LICENS	E NUMBER	PAY THIS	JAFRET :	9ATE 1	O BE RE	NEWED	LATE FEE
CODE	TYPE	REGISTRATION NO	AMOUNT	19.2	MO	DA	YR	LATEFEE
MD	1	33413	\$100	100	03	09	87	

NICHOLAS PANTELAKIS NORTH SHORE MED PK ESSEX CENTER DR PEABODY, MA 01960

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

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 QUESTIC	ONS 1-26			
1. Print Name: NICHOLDS PANTELAKIS	JNG 1-20.	2. Date of Birth:		
3. Medical School: Boston university M.D.? D.O.? (	Check One.)	/ / / / n	MONTH DAY	YEAR
4. Country where Medical School located: 5. Date	of Graduation:	4/1/	0	
American Specialty Board Certified?  (Check if yes.)		. /		
Which Boards?				
7. Principal Specialty(les): OBSTETVICS and by mecology 8. Princ	ipal work setting:	VIVATE	OFFIC	P
9. Home address:	ipal business address: .	SAME	AS 1	4 Bove
1. List all hospitals at which you have currently effective privileges: Hunt Hespitals	; Bever	Y HOSPITAL	, V.B.Th	emos
2. List all hospitals at which you have held privileges in the past 20 years: Beth ISR	sel ; Ly	NN; Wi	va Uni	ch!
3. States other than Massachusetts in which you are presently licensed to practice:	Mon	18		
4. List any other states where you were previously licensed to practice:	Nowe	<del></del>		
5. Has any medical malpractice claim been made against you in the last ten years (whether or no	Ol a lewenit was filed in a	olotion to the eleimad	YES	NO
8. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic o		enation to the claim, r		4
7. Are any formal disciplinary charges conding or has any disciplinary action been taken against	t you in the last ten year	s, by any governmental		$\dashv$
authority, by any hospital or health care facility, or by any professional medical association (i.e. Has your privilege to possess, dispense or prescribe controlled substances ever been suspense or have you been called before or warned by this state or any other jurisdiction including a fee	ded revoked depled cos	teletad surrendered		-
9. Have you ever withdrawn an application for medical licensure or been denied a medical licens				1
0. Have you ever had any mental illness which has impaired your ability to practice medicine or	to function as a student	of medicine?		ĺ
1. Have you ever had an organic illness which has impaired your ability to practice medicine or t	to function as a student of	of medicine?		1
2. Are you now, or have you been in the past, dependent upon alcohol or drugs?				
3. Have you ever, for any reason, lost American Specialty Board Certification? 4. Have you been denied recertification by one or more specialty boards?	**************************************			-
If yes, which one(s)?	Ø1.4177			
5. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows:	ows: <u>CATE</u>	-ory I	102	
6. I am an active inactive practitioner. (Check One.)				
HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FOR URBUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FF BLE CHARGE FOR MY SERVICES.	RM (FRONT AND BACK) ROM A MEDICARE BENE	INCLUDING ATTACHED FICIARY MORE THAN	SHEETS IS TRI THE MEDICARE	UE. REASON-
URSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, T ETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NOTE: THIS APPLIES	O MY BEST KNOWLEDGE S EVEN IF YOU DESIDE	SIGNATU	FILED ALL STAT TOF THE COUN	E TAX
	DATE:	3/3/8	<u> </u>	***************************************
(See Reverse Side)				

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

Fill in name and number. Physician Last Name: PANICLAK. 5	Registration No.: 33413
12. a) Other States where you are now licensed to practice (Abbreviate):	
12. b) States where you previously were licensed to practice (Abbreviate):	
13. I am applying to be registered with the following status:  ACTIVE **INACTIVE # ACTIVE # INACTIVE # INACTIV	, answer questions 14. a) through c). /E, 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 Category I: 10.3 hrs., Category II: 21. hrs., (Risk-Management: 10.4 hrs.); Residency Program In:  Walver Requested (You must fill out a separate Waiver Form.)	or type of residency, or check walver.)
14. b) My medical malpractice insurance is covered by INSURANCE CARRIER.  LETTER OF CREDIT. If applicable insurer:  Or A institution issuing Letter of Credit:  Atternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice in NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE.  OTHERWISE EXEMPTED. (State how)	nsurance because I am (Check one)
14. c) Percent of Practice Time In Massachusetts: 100 %	
Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide detail	lls 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 relati	
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 Instru against you by any governmental authority, hospital or other health care facility, or professional medical association (lineational, state or local)?	rctions) been taken nternational,
If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attack	
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Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide detail	ils in the next section. Yes No
18. Has your privilage to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted have you been called before or been warned by this state or any other jurisdiction including a federal agency?	ed, surrendered, or
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?	P4\$4 4 4 4144 1141111112P+\411784477
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of me	edicine?
21. Have you had an organic lilness 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):	



#### 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

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if 999, write Name(s):  nereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.  suant to M.G.L. c476, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.  suant 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 tairns 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.  reby certify under the penalties of perjury that all information on this formtront and back and (#)   attached pages is true.		2 <u>6 S</u>	Fa	cility Code:		_ Fa	cility Cod	e:	Facility	y Code:		Facility Code	
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# 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

•Remit \$400.00 for renewal fee (non- •Add late fee of \$25.00, if necessary	refundable). • Return renewal application in GREEN envelope. • Enclose check with coupon in BLUE envelope.
Please review carefully the following	g information for active and completeness. Make any corrections or s must be answered or your renewal will be delayed.
1. Current Status: Active R	egistration No.: 33413 Renewal Date: 03/09/2003
If you want to change your current status, plea	se check <u>one</u> of the following boxes to indicate your <u>new</u> status: (Check only one)
☐ Active ☐ Retiring (see instruction	ons)
2. Other Name(s), if any, under which you wer	re licensed. Please make corrections (print)
A) Mailing/Business Address: 3. NICHOLAS PANTELAKIS 6 ESSEX CENTER DRIVE SUITE 201	Other Name(s) Name Change (enter name below)  Mailing Address:
PEABODY, MA 01960-2910	City/Town: State:
B) Home Address:	Zip: Country:
	Business Address:  City/Town:  Zip:  Country:  Business Telephone: ()
Home Phone:	Home Address:  City/Town:  Zip: Country:
Business Phone:	Home Telephone: (
a) Date of Birth: b) Sex:	7. Current American Board of Medical Specialties Certification (See Table 2)
c) SS#:	Code: Code:
i) Name of Medical School:	8.Drug License Numbers, if any: a) Federal (DEA):
Boston University School of Medicine  b) Year Graduated: 1970 c) Degress p	b) Massachusetts:
ecialty Code(s) (See <u>Table 1</u> )  de(s) Hours per Week in Mass.	9. a) Other states where you are now licensed to practice (Abbr.)
OBG 0 Obstetrics and Gynecolog	b) States where you were previously licensed (Abbr.)
ext to each facility, write the approximate percent	you are affiliated or have completed the credentialing process for the provision patient a check mark next to those health care facilities where you have admitting privinges (AP) tage of patient care hours that you provide in each facility) No affiliation.
cility Code: 58/ (AP) 100 % Facil cility Code: 534/ (AP) — % Facil 999, print name(s):	Sity Code: / (AP) % Facility Code: / (AP) % Sity Code: / (AP) % Facility Code: / (AP) %

	12. Tr/ 10.10	レナベ
	PANTELAKIS LICENSE NUMBER: 339	15 '
11. My medical malpractice insurar	nce is covered by Insurance Carrier Letter of Credit	O 29
Insurer's name. (Required):	1eDical Protective Co. Policy dates: From: 8/9/02 To: 8	17103
Alternatively indicate as follow	I am registering with Active status but I am not covered by medical malpractice Not involved in direct/indirect patient care in Massachusetts A government	insurance
Otherwise exempt Please ex		
<ol> <li>What is your principal work set for the provision of patient care</li> </ol>	ting? (See Table 4) 5 If you are affiliated with a healthcare facility or you must complete question #10 on page 1 and list your affiliations.	credentialed
13. Care of patients in Massachuset	its (see instruction booklet).	
1) Average weekly hours in	nvolved in: A) inpatient care	
2) What is the approximate	percentage of your patient care hours in primary care? 30 %	
PART A - QUESTIONS RE	FER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTI	ONS)
question. Provide details on Form and definitions. ALL questions in	the period since you signed your last renewal application. Check either YES or land Refor all YES answers (except question 22). Refer to instructions for additional this section must be answered. Do not answer NA or the form will be incompleted.	al intermation
		YES NO
14. CLAIMS MADE (New or Per	nding): Has any medical malpractice claim been made against you that has not	i
vet been finally settled or adjud	licated, whether or not a lawsuit was filed in relation to the claim?	
15. CLAIMS (Resolved): Has an adjudicated, or otherwise resolv	yed, whether or not a lawsuit was filed in relation to the claim?	
16. Has any lawsuit, other than a m	edical malpractice suit, which is related to your competency to practice medicine,	
otherwise resolved?		
17. Have you been charged with an	• 1	
any governmental authority, he	alth care facility, group practice or professional society or association?	
restricted by, or surrendered to	any state or federal agency?	
= ::		
co-payment, or placed any cond you voluntarily restricted, limit	lition related to professional competency or conduct on your coverage, or have ed or terminated your insurance coverage in response to an inquiry by a	
	- ·	☐ No
	or 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 wai	iver or exemptions. Do not submit documentation of your CMEs with applicati	on.
and the punishment for fail	c 1A, I understand my obligations to report abuse or neglect of children under G.L. cure to comply.	
amount.		
Massachusetts state tax reti	A, I certify that I have complied with all laws of the Commonwealth related to the fourns and payment of all Massachusetts state taxes; reporting of employees and contraining and remitting child support pursuant to G.L. c. 119A. (See instructions).	ding of actors to der
I hereby certify under the penals	ties of perjury that all information on this Renewal Application, Part B and For	_
		120103
	and include PARI'B, WITH YOUR RENEWAL APPLICAT require that you notify the Board, in writing, of any change of addr	
nuestion. Provide details on Form and definitions. ALL questions in your renewal.  14. CLAIMS MADE (New or Per yet been finally settled or adjuding to the per get been finally settled or adjuding to the per get been finally settled or adjuding to the per get been finally settled or adjuding to the per get been finally settled or adjudicated, or otherwise resolved?  15. CLAIMS (Resolved): Has an adjudicated, or otherwise resolved?  16. Has any lawsuit, other than a mor your professional conduct in otherwise resolved?  17. Have you been charged with or any governmental authority, here the per gover	A R for all YES answers (except question 22). Refer to instructions for additional this section must be answered. Do not answer NA or the form will be incompleted to the claim?  In this section must be answered. Do not answer NA or the form will be incompleted to the claim?  In medical malpractice claim that has been made against you been settled, and whether or not a lawsuit was filed in relation to the claim?  In whether or not a lawsuit was filed in relation to the claim?  In the practice of medicine, been filed against you or been settled, adjudicated or the practice of medicine, been filed against you or been settled, adjudicated or the practice of medicine, been filed against you or been settled, adjudicated or the practice of medicine, been filed against you or been settled, adjudicated or the practice of medicine, been filed against you or been settled, adjudicated or the practice of alth care facility, group practice or professional society or association? It is present the controlled substances been suspended, revoked, denied, any state or federal agency?  It is for a medical license or been denied a medical license for any reason? It is the provider restricted, limited, terminated, imposed a surcharge or insurance provider restricted, limited, terminated, imposed a surcharge or insurance provider minuted your insurance coverage in response to an inquiry by a provider?  In the professional competency or conduct on your coverage, or have ed or terminated your insurance coverage in response to an inquiry by a provider?  In the provider of the professional competency or conduct on your coverage, or have ed or terminated your CME requirements preceding your renewal date?  Yes to form must be submitted at least 30 days prior to license expiration date.  One: In lactive status Residency/Fellowship training (See instructions) liver or exemptions. Do not submit documentation of your CMEs with application in the Medical Lactice of perjury that all massachusetts state taxes; reporting of employees and contraini	YES NΩ  VES NΩ  Intermation  The and delay  YES NΩ  The area of the second of the sec

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

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# Massachusetts Physician Renew

Physician Name: NICHOLAS PANTELAKIS

Application

Ø no4

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(3) Do you perform any surgery in your office? (See Rent-Wal Instrumental page 5)

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered.

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 mulpractice 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.
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:
8) 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) I mactive Status Residency/Fellowship training

Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

PART A					
1) Current Status: Active	Renewal Due Date	e: 02/09/2007 Birth Date:			
If you want to change your current status, please check <u>one</u> of the following boxes to indicate your <u>new</u> status:  Cheek only one: (See Renewal Instructions, page 3.)					
☑ Active ☐ Retiring		ctive			
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 <a href="#">CANNOT</a> be a Post Office Box.  Please make corrections (print)					
2a) MAILING ADDRESS	RECEIVED	rease make corrections (prair)			
6 Essex Center Drive	2009	Mailing Address:			
	IAR 2 2007	1			
Peabody, MA 01960-2910	rd of Dagistration	City/Town: State:			
Check here to change this address	· ···································	Zip: Country:			
2b) HOME ADDRESS					
		Home Address:			
		City/Town:State:			
		Zip: Country:			
D)		Home Telephone: ( )			
Phone:  Check here to change this address		Home address cannot be a Post Office Box			
2c) BUSINESS ADDRESS		D A.11			
6 Essex Center Drive	•	Business Address:			
Suite 201		City/Town: State:			
Peabody, MA 01960-2910		Zip: Country:			
		Business Telephone: ( )			
Phone: (978)531-4848		Business address cannot be a Post Office Box			
Check here to change this address		Correct your E-mail and Fax Number below:			
3) E-mail Address:					
4) Fax Number: 978-531-6036					
5) Specialties (See Renewal Instructions, page		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:	List Certifying Board(s) below:  Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.				
Board Name ABMS or AOA	Certificate/Subs	pecialty Delete?			
		Д			

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- Q

## Massachusetts Physician Renewal Application

License No.: 33413 Physician Name: Nicholas Pantelakis, M.D. Please make corrections as necessary (See Renewal Instructions, page 4.) 8) Other states where you are now licensed to practice 7) Drug License Numbers Corrections: a) Massachusetts: 9) States where you were previously licensed b) Federal (DEA): c) Federal (DEA) XS: 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 Location State Delete? (City or Town) (See above and description on page 4.) Melrose-Wakefield Hospital 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 10 hrs/wk Average weekly hours involved in: a) inpatient care Change to: \_\_\_\_ hrs/wk 20 hrs/wk Change to: hrs/wk b) outpatient care 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: ProMutual Group From 38/06/06 To 08/06/07 Policy dates: Occurrence Policy Claims made with tail coverage Type of 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: Not involved with direct or indirect patient care in Massachusetts Check one: 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.

Physician Name: Nicholas Pantelakis, M.D.

License No.: 33413

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	7.7.	
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?		
<ul> <li>18) INVESTIGATIONS AND DISCIPLINARY ACTIONS         <ul> <li>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?</li> </ul> </li> </ul>	PR-12-12-11	
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?	<u></u>	
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?	· made	-
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?		
A CME waiver request form must be submitted at least 30 days prior to your license expiration date.		ĺ
c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)		
CME EXEMPTION: (check one)		ĺ

License No.: 33413 Physician Name: Nicholas Pantelakis, M.D.

#### **PART C**

#### Ì PHYSICIAN PROFILE Check One: $\mathcal{G}_{1}$ 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.) (j) 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. 1 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:

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.

Massachusetts Physician	Renewal Application
Physician Name: Nicholas Pantelakis, M.D.	License No.: 33413
NATIONAL PROVIDER In the primary purpose of the NPI is to uniquely identify health care purpose all other identifiers assigned to health care provand health care purchasers for purposes of conducting these business. Under the final HIPAA NPI Rule, all individual and organization control of the purpose of	DENTIFIER (NPI)  oviders as "health care providers" in HIPAA standard transactions.  riders, such as those assigned by health plans, government programs transactions.
Option 4: Authorize the Board of Registration in Medicine to apply to Option 5: If your license status is INACTIVE, you may elect not to compare the status of the compared to	alid NPI. You can apply for an NPI directly by using the NPPES we have not received it yet. Once you have received your NPI Number, at the Board's web site at <a href="https://www.massmedboard.org">www.massmedboard.org</a> . PI on your behalf and you have not received it yet (supply ober, you must notify the Board by completing the NPI form at the for an NPI on your behalf. Obtain an NPI number.
Check the appropriate box below, supply appropriate information, an My current NPI is: 1205725775	
☐ I have applied for an NPI using a third party (enter name):	
☐ By checking this option and signing the bottom of this page, I h	·
☐ As an <i>inactive</i> physician, I do not wish to obtain an NPI.	and the second to apply to an in the sound to the second to
Please provide the HIPAA taxonomy (specialty) codes (refer to Rene providing the taxonomy code, please indicate your specialty in the spetaxonomy code is required if you authorize BORIM to apply for an N	wal Instructions, page 21 for more information). In addition to
Taxonomy (Specialty)	Code Taxonomy Description (Print)
Primary Provider Taxonomy: 207V000	O OX OBSTETTICS & BYNECOLOGY
Provider Taxonomy:	
NPI REQUIRED INFORMA	ATION
In an ongoing effort to improve the quality of the information we colle as necessary. Please note: This information is required if you authorize	ct, please review the following information and make corrections
Social Security Number:	
State of Birth (if US): Country of	if Birth (if outside the US):
Gender:	4944
Penalties for Falsifying Information on the 18 U.S.C. 1001 authorizes criminal penalties against an individual whethe United States knowingly and willfully falsifies, conceals or covers fictitious or fraudulent statements or representations, or makes any fals fictitious or fraudulent statement or entry. Individual offenders are sub Offenders that are organizations are subject to fines of up to \$500,000 derived by the offender if it is greater than the amount specifically authorized.	o in any matter within the jurisdiction of any department or agency of up by any trick, scheme or device a material fact, or makes any false, se writing or document knowing the same to contain any false, ject to fines of up to \$250,000 and imprisonment for up to five years.  18 U.S.C. 3571(d) also authorizes fines of up to twice the gross gain
Authorization for Mathorization for Mathorizatio	PI to any authorized hospital, health plan, or health organization.  M. Date: 2/28/07
MAKE A COPY OF YOUR APPLICATION AND ALL ATTAC	CHMENTS BEFORE MAILING. YOU MUST RETAIN A

COPY OF YOUR APPLICATION FOR YOUR RECORDS, FOR CREDENTIALING AND OTHER PURPOSES. Page 7 of 9

# Massachusetts Physician Renewal Application Physician Name: NICHOLAS PANTELAKIS License No.: 334

License No.: 33413

PART A			
1) Current Status: Active	Danawal Dua	Date: 02/09/2005 Birth Date:	
		eck one of the following boxes to indicate your new status:	
	ee Renewal Instructions, page		
		Inactive	
		r 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 <u>CANNOT</u> be a Post Office Box.			
2a) MAILING ADDRESS		Please make corrections (print)	
6 ESSEX CENTER DRIV		Mailing Address.	
SUITE 201	F 462	Mailing Address;	
PEABODY, MA 01960-2	2910	City/Town: State:	
	1 ~	Zip: Country:	
Check here to change th	ns address		
2b) HOME ADDRESS	2005 JAN 31 PM 12:	Home Address:	
,	19 = 13	City/Town:State:	
·	CC → → - <	Zip: Country:	
Phone:	ल हैं	Home Telephone: ()	
Check here to change the		Home address cannot be a Post Office Box	
2c) BUSINESS ADDRES			
6 ESSEX CENTER DRI		Business Address:	
SUITE 201		City/Town: State:	
PEABODY, MA 01960-	2910	Zip: Country:	
		Business Telephone: ()	
Phone: (978)531-4848		Business address cannot be a Post Office Box	
Check here to change th	is address	Districts to the control of a root office mon	
3) E-mail Address:			
4) Fax Number: 97	8 531 6036	<u></u>	
5) Specialties (See Renewal In	nstructions, page 4.) Bel	lete? Additional specialties:	
Obstetrics and Gynecology	[		
	<u>,                                    </u>		
	<u> </u>		
6) Current American Roard	of Medical Specialties (AR)	MS) or American Osteopathic Association (AOA) Information.	
(See enclosed instructions and			
List Certifying Board(s) bel	ów.	Update General Certificates and Subspecialty Certificates	
Dist Cottajag nomago ven	P77 *	below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty Correct? Delete?	
		,	

License No.: 33413

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Physician Name: NICHOLAS PANTELAKIS Please make corrections as necessary (See Renewal Instructions, page 4.) 8a) Other states where you are now licensed to practice (Abbr.) 7) Drug License Numbers, if any: a) Massachusetts: 8b) States where you were previously licensed (Abbr.) b) Federal (DEA): c) Federal (DEA) XS: 9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Private Office Hours per Week: 20 Change to: 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 [ # Hours Staff Category Health Care Facility (See Renewal Instructions, page 4.) Delete? per Week Current Change 10 Melrose-Wakefield Hospital Admitting M Northeast Hospital Corporation П П 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Change to: /o hrs/wk 8 hrs/wk Average weekly hours involved in: a) inpatient care Change to: 20 hrs/wk 30 hrs/wk b) outpatient care 12) Medical Liability Insurance Information (See Renewal Instructions, page 5.) My medical liability insurance is provided through: (check one) Insurance Carrier (complete below) Change to: Pro Mutual Group Current Insurance Carrier: Medical Protective Co From 08/06/2004 To 08/06/2005 Policy dates: (required) Letter of Credit subject to Board approval (attach a copy) I am registering with Active status but I am not required to have medical liability insurance because I am: Check one: Not involved with direct or indirect patient care in Massachusetts ☐ Government Employee Federal Tort Claims Act (FTCA) Otherwise exempt (Please explain):

Physician Name: NICHOLAS PANTELAKIS License No.: 33413

13) Do you perform any surgery in your office? (See Renewal Instructions, page 5.)	
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 <u>Form R</u> 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	1	
a) Have you been charged with any criminal offense during this time period?	1	
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? X 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.)	o	
c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8  CME EXEMPTION: (check one)	(.)	

Physician Name: NICHOLAS PANTELAKIS License No.: 33413

#### PHYSICIAN PROFILE

Ŕ	I have reviewed my Physician Profile at <u>profiles,massmedboard.org</u> 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 periury.
- 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.

Date: 0/ /2// 05

Signature:

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

Page 5 of 5

1. 40.2 1.

CJ"

# 01/20/100 OI

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# Massachusetts Physician Renewal Application

Physician Name: Nicholas Pantelakis, M.D.

License No.: 33413

PART A

PART A				
-,				
		e of the following boxes to indicate you	ur <u>new</u> status:	
Check only one: (See Renewal Instru	ucnons, page 3.)	tive Do not wish to	renew	
de Active 🗀 Retning	£., 1000			
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 <u>CANNOT</u> be a Post Office Box.  Please make corrections (print)				
2a) MAILING ADDRESS	1	Trease mane corrections (print)		
6 Essex Center Drive		Mailing Address:		
Suite 201		City/Town:	- 11	
Peabody, MA 01960-2910	ersiCD	Zip: Country:	l I	
Check here to change this address	CEIVED			
2b) HOME ADDRESS	2 1 2009	Home Address:		
Board of	f Registration	City/Town:	State:	
In Medicine		Zip: Country:	LI LI	
		Home Telephone: ()		
Phone:  Check here to change this address	· ·	Home address cannot be a Post		
26) BUSINESS ADDRESS		Business Address:		
6 Essex Center Drive		Business Address:  City/Town: State:		
Suite 201 Peabody, MA 01960-2910				
reabody, MA-01900-2310		Zip: Country:		
Phone: (978)531-4848		Business Telephone: ()		
Check here to change this address		Business address cannot be a Post Office Box		
3) E-mail Address:		Correct your E-mail and Fax Num	ber below:	
4) Fax Number: 978-531-6036				
5) Specialties (See Renewal Instructions, pag	e 4.) Delete?	List Additional Specialties:		
Obstetrics and Gynecology				
Observed and Cylindonesy				
:				
6) Current American Board of Medical Sp (See enclosed instructions and Renewal Instru	ecialties (ABMS) ( uctions, page 4.)	or American Osteopathic Association	(AOA) Information.	
List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.			
Board Name ABMS or AOA	Certificate/Subs	pecialty	Delete?	
			0 .	
			D	
			0	

Physician Name: Nicholas Pantelakis, M.D. (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: 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 Location State Delete? (See above and description on page 4.) (City or Town) Melrose-Wakefield Hospital MeLrose 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 10 hrs/wk Average weekly hours involved in: a) inpatient care Change to: \_ 20 hrs/wk b) outpatient care 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) Change to: Hub International NE.
Medical Protective Current Insurance Carrier: ProMutual Group To 08/06/69 From 08/04/08 Policy dates: 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.

Physician Name: Nicholas Pantelakis, M.D.

License No.: 33413

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	<del> </del>	
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?		
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)		ſ

## Massachusetts Physician Renewal Application

Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

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#### 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. П 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.

Date:

Signature:

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.

Page 5 of 7



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

Current Status: Active License Expiration Date: 3/9/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

Home Address:

Business Address: 6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

(978) 531-4848

3) Email Address:

4) Fax Number: (978) 531-6036

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

None Reported

7) Drug License Numbers

Massachusetts Federal (DEA) Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

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

WorkSite Location

Melrose-Wakefield Hospital Melrose-Wakefield Hospital

Melrose

Page 1 of 5 Date: 1/14/2011 Time: 2:49 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 3 hrs/wk

b) outpatient care 6 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier Medical Protective Co Policy Start Date

**Policy End Date** 

Policy Type

08/06/2010 08/06/2011

Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
- b) Have you 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?

Page 2 of 5 Date: 1/14/2011 Time: 2:49 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

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)

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?

Page 3 of 5 Date: 1/14/2011 Time: 2:49 PM



Physician Name: Nicholas Pantelakis, M.D.

Current Status: Active

License Expiration Date: 3/9/2015

License No.: 33413

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

Home Address:

**Business Address:** 

6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

(978) 531-4848

3) Email Address:

4) Fax Number: (978) 531-6036

5) Specialties

Obstetrics and Gynecology

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

None Reported

ABMS/AOA **Board Name** 

Certification

Subspecialty

7) Drug License Numbers

Massachusetts

Federal (DEA)

Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

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

**WorkSite** 

Location

Melrose-Wakefield Hospital Melrose-Wakefield Hospital

Melrose

Page 1 of 5 Date: 1/10/2015 Time: 2:47 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

11) Care of patients in Massachusetts

Average weekly hours involved in: a) ir

a) inpatient care 3 hrs/wk

b) outpatient care 6 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier
Hub International New England

Policy Start Date 08/06/2014

Policy End Date 08/06/2015

Policy Type Occurrence Policy

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

#### 14) Claims Made

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

#### 15) Claims Closed

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

#### 16) Other Civil Lawsuits

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

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

#### 17) Criminal Charges

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

#### 18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
- b) Have you taken a leave of absence from any health care facility, group practice or employer 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?

Page 2 of 5 Date: 1/10/2015 Time: 2:47 PM



**Physician Name:** Nicholas Pantelakis, M.D. License No.: 33413

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

Page 3 of 5 Date: 1/10/2015 Time: 2:47 PM



License No.: 33413

Physician Name: Nicholas Pantelakis, M.D.

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?

Page 4 of 5 Date: 1/10/2015 Time: 2:47 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

Current Status: Active License Expiration Date: 3/9/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address: 6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

Home Address:

Business Address: 6 Essex Center Drive

Suite 201 Peabody

Massachusetts - 01960-2910 United States of America

(978) 531-4848

3) Email Address:

4) Fax Number: (978) 531-6036

5) Specialties

Obstetrics and Gynecology

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

Information

ABMS/AOA Board Name Certii
None Reported

Certification

Subspecialty

7) Drug License Numbers

Massachusetts Federal (DEA) Federal (DEA) XS

8) Other states where you are now licensed to practice

None Reported

9) States where you were previously licensed

None Reported

10) Work Sites

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

WorkSite Location

Melrose-Wakefield Hospital Melrose

Melrose-Wakefield Hospital Melrose

Page 1 of 5 Date: 1/29/2013 Time: 12:58 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

11) Care of patients in Massachusetts

Average weekly hours involved in:

a) inpatient care 3 hrs/wk

b) outpatient care 6 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier
Medical Protective Co

**Policy Start Date** 

**Policy End Date** 

Policy Type

08/06/2012

08/06/2013

Occurrence Policy

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

14) Claims Made

a) New: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you during this time period?

b) Pending: Are there any unresolved malpractice claims against you today, i.e., any claims that have not been resolved, settled or adjudicated during this time period?

15) Claims Closed

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

16) Other Civil Lawsuits

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

a) New: Have there been any claims, other than medical malpractice claims, filed against you during this

time period?

b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

a) Have you been charged with any criminal offense during this period?

b) Have any criminal offenses/charges against you been resolved during this time period?

c) Are there any criminal charges pending against you today?

d) Are any Application of Issuance of Process pending against you?

18) Other Issues

a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?

b) Have you 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?

Page 2 of 5 Date: 1/29/2013 Time: 12:58 PM



Physician Name: Nicholas Pantelakis, M.D. License No.: 33413

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

Page 3 of 5 Date: 1/29/2013 Time: 12:58 PM



**Physician Name:** Nicholas Pantelakis, M.D. **License No.:** 33413

23)	Do you have a medical	condition that i	interferes in ar	ny 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?

Page 4 of 5 Date: 1/29/2013 Time: 12:58 PM



DINESH PATEL, M.D. CHAIRMAN

ALEXANDER F. FLEMING EXECUTIVE DIRECTOR

Ten West Street Boston, Massachusetts 02111

Commonwealth of Massachusetts Board of Registration in Medicine

(617) 727-3086

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

August 24, 1992



Nicholas Pantelakis, M.D. North Shore Medical Park Essex Center Drive Peabody, Massachusetts 01960

Re:

Docket No. 90-012

Dear Dr. Pantelakis:

The Complaint Committee of the Board has considered the above referenced complaint and has determined that the complaint should be dismissed.

Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. Should you have any questions, please feel to contact me at the above address.

Very truly yours,

Peggy Holland Chief Investigative Attorney



#### DINESH FATEL, M.D. CHARMAN ALEXANDER F. FLEMING EXECUTIVE DIRECTOR

# Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street Boston, Massachusetts 02111

(617) 727-3086

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

August 24, 1992

Re: Nicholas Pantelakis, M.D.

Docket No. 90-012

Dear

The Complaint Committee of the Board carefully considered the information you have furnished us regarding the physician named above as well as the physician's written response to it.

After a thorough review of this evidence, the Committee determined that the complaint should be dismissed and that your complaint and the physician's response should be placed in the Board's permanent record of the physician.

While the Committee declined to recommend the initiation of formal disciplinary action in this case, it is appreciative of your actions in bringing this matter to its attention. Should you have any questions or additional material which you wish the Board to consider, please contact me at the above address.

Very truly yours,

Peggy Holland

Chief Investigative Attorney

10



## Commonwealth of Massachusetts Board of Registration in Medicine

#### Ten West Street Boston, Massachusetts 02111

(617) 727-3086

ANDREW G. BODNAR, M.D., J.D. CHAIRMAN

BARBARA NEUMAN EXECUTIVE DIRECTOR An Agency within the Executive Office of Consumer Affairs and Business Regulation May 10, 1990

Nicholas Pantelakis, M.D. North Shore Medical Park Essex Center Drive Peabody, Massachusetts 01960

RE: Complaint No. 90-112

Dear Dr. Pantelakis:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed. The Board is obligated by law to investigate such matters relating to the proper practice of medicine. In compliance with this mandate, the Board's Complaint Committee has directed the staff of the Board to gather information on all such complaints.

Please provide a written response to the issues raised in the enclosed material. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Please be advised that Board Regulation 243 CMR 2.07 (12) requires that you respond within thirty days of your receipt of this letter. Your response should be sent to the Complaint Coordinator, Disciplinary Unit, at the above address. After your response is received, the case will be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will in any event be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Raiph A. Deterling, Jr., M.D. Chairman, Complaint Committee

Enclosure

Members of the Board: Raiph A. Deterling, Jr., M.D. Vice Charmen Paul G. Gittin, J.D.

Marianne N. Prout, M.D. Physician Member Marian J. Ego. J.D., Ed.D. Donna M. Norrs, M.D. Physician Member Dinesh Patel, M.D.

## Nicholas Pantelakis, M.D.

NORTH SHORE MEDICAL PARK ESSEX CENTER DRIVE PEABODY, MASSACHUSETTS 01960 (508) 531-6666

5-25-90

To Whom It May Concern:

underwent a suction dilatation and evacuation to terminate a pregnancy. All the possible risks and complications of the procedure were explained to her before the procedure. She understood the risks and wanted to go ahead with the procedure. Unfortunately, during the procedure, the uterus was perforated and she sustained a laceration of the right ovary and avulsion of a segment of small bowel. The perforation was recognized immediately and proper procedure was followed; namely, consultation and assistance of a general surgeon for exploratory laparotomy and repair of damages.

I never made the statement that "I made a little mistake". I informed her of the perforation and the complications that required the assistance of a general surgeon. I never said there was a "slip of the instruments".

states that she called my office a number of times for a statement of what happened and that I never responded. I have no record of any such calls and my office personnel do not have any recollection of any such calls.

Please note, also, that has filed a lawsuit against me, in which she makes the same allegations which are made in her complaint.

Sincerely,

Nicholas Pantelakis, M.D.

NP/dmd

\*\*\*

## Commonwealth of Massachusetts Board of Registration in Medicine

## Ten West Street Boston, Massachusetts 02111

(617) 727-3086

W

ANDREW G. BODNAR, M.D., J.D. CHAIRMAN

BARBARA NEUMAN EXECUTIVE DIRECTOR An Agency within the Executive Office of Consumer Affairs and Business Regulation

#### COMPLAINT INFORMATION DATA FORM

This form is to be completed by the person making the complaint against physician. Please return this form to: Robyn Gopin, Complaint Coordinator the above address.
Complainant's Name:
Complainant's Address:
MAILING ADDRESS:
Daytime Phone Number:
Are You Making This Complaint on Behalf of Yourself? Yes Y No
Patient's Address:
Patient's Daytime Phone Number: ()
Full Name of Physician(1): NICHOLAS PANTELAKIS
Address of Physician(1): ESSEX DRIVE PEABODY, MASS.
Full Name of Physician(2):
Address of Physician(2):

Members of the Board Manap J. Ego. J. D., Ed D. Vice Chauman Manaphili N. Prout, M.D.

Raiph Al Deterling, Jr., M.D. Physician Member Paul G. Ottini, J.D.

Louise Liang, M.D.
Physician Member
Dinesh Patel, M.D.
Physician Patel, M.D.

1.	X Improper medical treatment	
2.	Sexual misconduct	W
3.	Failure or refusal to render treatment	
4.	Breach of confidentiality	
5.	Unprofessional conduct	•
6	Inaccessibility or failure to release medical records	
7.	Incorrect or incomplete information in medical records/reports	
8.	Incorrect or excessive billing	
9.	Improper prescribing practices	
misco	se state the facts which you believe show the physician committee and act. Attach copies of any records, bills, letters or other information which may be helpful in investigating your complaint. If additional if required, please use an 8 1/2 x 11 sheet of paper.	•
	WHEN I WAS ADMITTED TO THE I WAS TO BE DISCHARED IN A FEW HOURS.	
	BECAUSE OF DR. PANTELAKIS IWAS THERE FOR ALMOST TWO WEEKS. THE WAY	
	DR. PANTELAKIS PUT IT WAS "I MADE A LITTLE MISTAKE AND HAD TO CALL	
	A SURGEON IN. "BECAUSE OF HIS SLIP WITH THE INSTUMENTS I HAD TO PAVE	
	BLOOD TRANSFUSIONS PLUS OPERATIONS THAT I WOULD NOT HAD TO HAVE IF	
	HE HAD NOT FOULED UP. BECAUSE OF HIS IMPROPER MEDICAL TREATMENT I	
	LOST A FOOT OF BOWEL PLUS PROBLEMS WITH MY OVARY AND UTERUS.	
	THE PAIN THAT I AM HAVING IS UNBEARABLE, I ALSO KNOW BECAUSE OF ALL	
	THIS I AM UNABLE TO COPE AS A WIFE AND MOTHER SINCE THIS HAS HAPPENET	)
	I AM UNDER THE CARE OF THE MENTAL HEALTH CENTER LYNN, MASS.	
	I HAVE CALLED THE DOCTORS OFFICE A NUMBER OF TIMES WHEN THIS HAPPENED FOR A STATEMENT OF WHAT HARPENED BUT HE NEVERRESPONDED.	n.
	(Signature or compression).	
	As a series and a	
	NOVEMBER 25,1989 (date)	
	NOVEMBER 25,1989 (date)	