



10230192

Physician Registration Renewal Application

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

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

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

REDACTED COPY

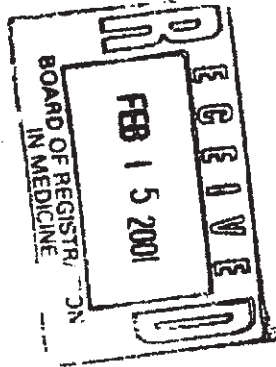
1. Current Status: Active Registration No.: 43434 Renewal Date: 03/19/2001
 If you want to change your current status, please check one of the following boxes to indicate your new status: (Check only one)

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

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

Please make corrections (type or print)

3. A) Mailing/Business Address:
 JOAN E LISTER



B) Home Address:

Other Name(s): _____
Mailing Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____
Business Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____ Business Telephone: (____) _____
Home Address: _____ City/Town: _____ State: _____ Zip: _____ Country: _____ Home Telephone: (____) _____
PLEASE NOTE: No P.O. Box addresses for home or business addresses.

Home Phone:

Business Phone:

4. a) Date of Birth: _____ b) Sex: F
 c) SS#: _____
 5. a) Name of Medical School:
Tufts University School of Medicine
 b) Year Graduated: 1977 c) Degree: M.D.
 6. Specialty Code(s) (See Table 1)
 Code(s) Hours per Week in Mass.
 OBG 0 Obstetrics and Gynecology
0

7. Current American Board of Medical Specialties Certification (See Table 2)
 Code: _____ Code: _____
 8. Drug License Numbers, if any:
 a) Federal (DEA): _____
 b) Massachusetts: _____
 9. a) Other states where you are now licensed to practice (Abbr.)

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

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

Facility Code: 501X (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
 Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
 If 999, print name(s): _____

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

AS A REGISTERED
 PHYSICIAN

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

SOC. SEC.
 NO. OR
 FEDERAL
 ID. NO.

YOU MUST SIGN BELOW

X *Joan E. Lister*
 APPLICANT'S SIGNATURE

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

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD		43434	100.00	100.00	01	15	84	

PLEASE PRINT ANY NAME OR ADDRESS
 CHANGES BELOW

JOAN E LISTER

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



COMM. OF MASS.
 P.O. BOX 8
 BOSTON, MASS. 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS
 CHECKS WILL NOT BE ACCEPTED.

DO NOT WRITE BELOW THIS LINE

3500600434340 011584 1000000009

DO NOT FOLD OR
 STAPLE THIS FORM

1. Principal Specialty(ies): * 30 18

2. Principal work setting: * 40

3. Home Address:

4. Primary work address: HCNP - Wellesley
230 Worcester St, Wellesley, Mass.

5. States other than Massachusetts in which you are licensed to practice: none

6. Has a judgement been returned against you in a malpractice suit since 1/15/82?

YES NO

7. Have you ever been convicted of any criminal offense other than minor traffic offenses?

8. Has any disciplinary action been taken against you in this state or any other?

9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?

10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows: * 05, 08

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

Jan E. Lister
SIGNATURE

* SEE CODE SHEET

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)



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

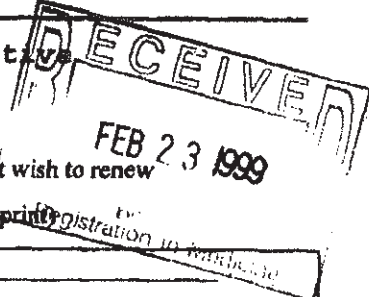
Before proceeding, please read the instruction booklet.

• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

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

Registration No.: 43434 Renewal Date: 03/19/1999 1. Current Status: Active



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

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

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

Please make corrections (type or print) registration in *blue*

3. A) Mailing Home Address:

JOAN E LISTER, M.D.

B) Business Address:
 DOCTORS BUILDING
 HOSPITAL AVENUE
 CLARKSBURG, MA 01247

Home Phone:

Business Phone: (413) 664-4343

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

5. A) Name of Medical School:
 Tufts University School of Medicine

B) Year Graduated: 1977 C) Degree: MD

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

Code(s)	Hours per Week in Mass.
OBG	60

 Obstetrics and Gynecology

Other Name(s): _____
Mailing Address: City/Town: _____ State: _____ Zip: _____ Country: _____
Other Address: City/Town: _____ State: _____ Zip: _____ Country: _____
Home: (____) _____ Business: (____) _____
Date of Birth: (M/D/Y): ____/____/____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F SS#: _____
Full Name of Medical School: _____
Year Graduated: _____ Degree: <input type="checkbox"/> M.D. <input type="checkbox"/> D.O.
Code(s) <u>OBGYN</u> Hours Per Week in Massachusetts <u>40</u>
If OS, Print Specialty: _____

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

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

Code: _____	Code: _____
Federal (DEA): _____	Mass: _____

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

Abbr: _____
Abbr: _____

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





Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

The Board will charge a fee for each copy.

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

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

Registration No.: **43434** Renewal Date: **03/19/97**

1. Activity Status: Active 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:

3. A) Mailing/Home Address:

JOAN E LISTER, M.D.

B) Business Address:

**DOCTORS BUILDING
 HOSPITAL AVENUE
 NORTH ADAMS, MA 01247**

Home Phone:

Business Phone: **(413) 664-4343**

4. A) Date of Birth: _____ C) Sex: **F**
 B) Lic. Issue Date: **09/21/78** D) SS#: _____

5. A) Name of Medical School:

Tufts University School of Medicine

B) Year Graduated: **77** C) Degree: **MD**

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

Code(s) Hours per Week in Mass.
OBG **70** **Obstetrics and Gynecology**

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

Code: **OG** Code: _____

8. Drug License Numbers, if any:

A) Federal (DEA): _____

B) Massachusetts: _____

9. A) Other states where you are now licensed to practice

Abbr: _____

B) States where you previously were licensed to practice

Abbr: _____

RECEIVED
ELM
2/18
CORRECTIONS (type or print)

Other Name(s): _____	
Mailing Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Other Address: _____	
City/Town: _____ State: _____	
Zip: _____ Country: _____	
Home: () _____	Business: () _____
Date of Birth (M/D/Y): ___/___/___	Sex (M/F): _____
Lic. Issue Date (M/D/Y): ___/___/___	SS#: _____
Full Name of Medical School: _____	
Year Graduated: _____ Degree (MD/DO): _____	
Code(s)	Hours Per Week in Mass.
_____	60
If OS, Print Specialty: _____	

Code: _____ Code: _____

Federal (DEA): _____
 Mass: _____

Abbr: _____
 Abbr: _____

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



I. PHYSICIAN INFORMATION

JOAN E LISTER
First Name Middle Initial Last Name Suffix

Make changes to name here

Mass License # 43434
License Status Active

First Issue Date 09/21/78

Hospital Affiliation

Doctors Building
Hospital Avenue
North Adams, MA 01247
U.S.A.
(413) 664-4343

North Adams Regional Hospital

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

HMO-Blue, HEMP, CIPA,
MOST other local
carriers.

Licenses Held in Other States:

Accepting New Patients? Yes No

Accept Medicaid? Yes No

(Please correct as necessary)

II. EDUCATION & TRAINING

Tufts University School of Medicine
Medical School

MD
Degree

77
Date

Make corrections here

Residency Program(s)

Start

End

Residency Program(s)

Start

End

Residency Program(s)

Start

End

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

<u>Nature</u>	<u>Date</u>	<u>Board Action</u>
---------------	-------------	---------------------

V. HOSPITAL DISCIPLINE

<u>Hospital</u>	<u>Date</u>	<u>Disciplinary Action</u>
-----------------	-------------	----------------------------

VI. CRIMINAL CONVICTIONS

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

.....

VII. MALPRACTICE

No. of Years in Practice: #

Details of claims paid for Dr. LISTER

Date	Amount Paid 0.0000	Basis for Complaint
Date	Amount Paid	Basis for Complaint
Date	Amount Paid	Basis for Complaint
Date	Amount Paid	Basis for Complaint
Date	Amount Paid	Basis for Complaint
Date	Amount Paid	Basis for Complaint

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, Honors

Publications

.....
.....
.....
.....
.....
.....

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

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

Registration No.	Status	Fee	Renewal Date	Late Fee
43434	ACTIVE	\$250.00	03/19/95	\$25.00

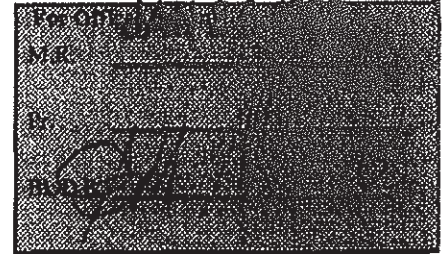
Mailing Address:
JOAN E LISTER, M.D.

Correction of Mailing Address

Address (Mailing): _____
City/Town: _____
State: _____
Country: _____ 01267

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

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



Pre-Printed Information

1. Other name(s), if any, under which you were licensed:
2. Home Address:
3. Date of Birth: _____ Sex: **F**
Lic. Issue Date: **09/21/78** SS#: _____
- Home Phone _____ Business Phone **(413) 664-4343**
4. Name of Medical School:
Tufts University School of Medicine
Year Graduated: **77** Degree: **MD**

Corrections of Pre-Printed Information

Name: _____
Address: _____
City/Town: _____
State: _____ Zip: _____
Country: _____
Date of Birth (M/D/Y): <u> / / </u> Sex (M/F): _____
Lic. Issue Date (M/D/Y): <u> / / </u> SS#: _____
Home: () _____ Business: () _____
Full Name of Medical School: _____
Year Graduated: _____ Degree (MD/DO): _____

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

6. Specialty Code(s) (See Table 1):
Code Hours per Week in Mass.
OBG 70 Obstetrics and Gynecology

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

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

Code: **OG** Code: _____

Code: _____	Code: _____
Federal (DEA): _____	Mass: _____

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

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

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

PRINT NAME AND NUMBER: Physician Last Name: LISTER Registration Number: 43434

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

Facility Code: 21 / (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)
Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

If 999, print name(s): _____

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

Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write name(s): _____

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

List Insurer: Mass. Medical Professional Insurance 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: _____ (ii) Otherwise exempt: _____

State how otherwise exempt: _____

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

13. a) What is your principal work setting? (See Table 4) 20

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? 40 hrs/wk

ii) How many hours per typical week are you currently involved in inpatient care in Mass? 30 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? 30 %
(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.

IN THE PAST TWO YEARS: YES NO

14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?

15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?

16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?

17. Have you been charged with any criminal offense, other than a minor traffic violation?.....

18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?

19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?

20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?

21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?

22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine? ..

23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?

24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?

25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested

No, training program exemption (see instruction booklet). _____
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

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

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

• Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.

• I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.

Signature: John E. Lister MD Date: 1/20/95

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

Registration No. 43434 Status ACTIVE Fee \$250.00 Renewal Date 03/19/93 Late Fee \$25.00

Correction of Mailing Address:

Mailing Address:
JOAN E LISTER, M.D.

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

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

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

For Office Use Only

M.R. FEB 11 1993

Pr. FR FEB 11 1993

Blk/D.E. 2/18/93 EN

Pre-Printed Information

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

b) Address (Business):
DOCTORS BUILDING
HOSPITAL AVENUE
NORTH ADAMS, MA 01247
3. Date of Birth: _____ Sex: F
Lic. Issue Date: 09/21/73 SS#: _____
Telephone Number:
Home _____ Business (413) 604-4343
4. Name of Medical School:
Tufts University School of Medicine
Year Graduated: 77 Degree: MD

Corrections of Pre-Printed Information

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

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____
Telephone Number:
Home: () _____ Business: () _____
Full Name of Medical School: _____
Year Graduated: _____ Degree (MD/DO): _____

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

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

Code	Hours per Week in Mass.
<u>06G</u>	<u>70</u>

Obstetrics and gynecology
0

Code	Hours per Week in Mass.
_____	_____
_____	_____

If OS, print specialty: _____

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
Code: 06 Code: _____
b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
Code: _____ Code: _____

Code: _____	Code: _____
Code: _____	Code: _____
Federal (DEA): _____	State (MA): _____

8. Drug License Number(s), if any: a) Federal (DEA) _____
b) State (MA) _____
9. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested _____
You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Lister Registration Number: 43434

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

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

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

List Insurer: JUA: MS 5382 (Policy#)

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: 01 / (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP) Facility Code: _____ / _____ (AP)

If 999, print name(s): _____

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

Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____ Facility Code: _____

If 999, write name(s): _____

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

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

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

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

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

Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question.

Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.

IN THE PAST TWO YEARS:

YES NO

15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

16. Have you been charged with any criminal offense, other than a minor traffic violation?.....

17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?.....

18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?

22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?

23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?.....

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

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

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

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

Signature: Joan E. Lister, MD

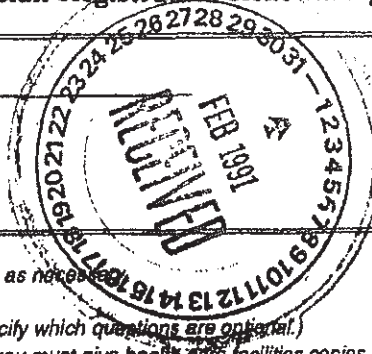
Date: 2/15/93



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
43434	ACTIVE	\$150	03/19/91

Dr. JOAN E LISTER
 DOCTORS BUILDING
 HOSPITAL AVENUE
 NORTH ADAMS, MA 01247-



For Office Use Only

M.R. _____
 Pr. JML 2/11/91
 Bk. _____ 2/11/91
 Ph. _____ 2/11/91
 O.E. _____ 2/5/91

Directions:

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

Activity Status:

I am applying to be registered with the following status: Active Inactive
 I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information

- Other Name(s), if any, under which you were licensed:
- a) Address (Home):
 DOCTORS BUILDING
 HOSPITAL AVENUE
 NORTH ADAMS, MA 01247-
- b) Address (Business):
 DOCTORS BUILDING
 HOSPITAL AVENUE
 NORTH ADAMS, MA 01247-
- Date of Birth: _____ Sex: f
 Lic. Issue Date: 09/21/78 SSN #: _____
 Telephone Number:
 Home _____ Business (413) 664-4343
- Medical School Code: HA007 Year Graduated: 77 Degree: MD
 Name of School:
 Tufts University School of Medicine
- a) Other States where you are now licensed to practice (Abbr):
 b) States where you previously were licensed to practice (Abbr):

Corrections of Pre-Printed Information

Name: _____
 Address: _____
 City/Town: _____
 State: _____ Zip: _____
 Country Code: _____ (if 999 write Country): _____
 Address: _____
 City/Town: _____
 State: _____ Zip: _____
 Country Code: _____ (if 999, write Country): _____

Date of Birth (M/D/Y): _____ / _____ / _____ Sex (M/F): _____
 Lic. Issue Date (M/D/Y): _____ / _____ / _____ SSN #: _____
 Home: (_____) Business: (_____)
 School Code: _____ Year Graduated: _____ Degree (MD/DO): _____
 If 99999, write School: _____

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

Code	Hours per Week in Mass.	Specialty
02G	0	Obstetrics and Gynecology
0	0	

Code _____ Hours per Week in Mass. 70
 If OS, write specialty: _____

7.a) Are you American Specialty Board Certified? (Y/N) y 7.b) If YES, Enter Codes:
 Code: 0G Board of Obstetrics and Gynecology
 Code: _____

Code: _____
 Code: _____

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA) _____
 c) State (MA) #M _____

b) How many DEA nos. do you have? 1

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

FILL IN NAME AND NUMBER:

Physician Last Name:

Lister

Registration No.:

43434

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

List Insurer:

N/A; Cookley, Pierpan, Dolan, & Collins

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

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:

(ii) OTHERWISE EXEMPT:

(State how otherwise exempt):

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

Facility Code: 61 (AP)

Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP)

If 999, write Name(s):

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

Facility Code: 921

Facility Code: 57

Facility Code: ___

Facility Code: ___

If 999, write Name(s):

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

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

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

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

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

a) How many hours per typical week are you currently involved in outpatient care in MA? 35 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in inpatient care in MA? 35 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (See Table 6) 2D

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

Yes No

15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?.....

16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?.....

17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--See Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?.....

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?.....

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?.....

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

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

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

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

Signature:

Joan E. Lister

Date

1, 15, 91

BOARD OF REGISTRATION IN MEDICINE

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

SOC. SEC. NUMBER, OPTIONAL

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD	1	43434	\$100	100	03	19	87	

JOAN E LISTER



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 QUESTIONS 1-26.

- Print Name: Joan E Lister
- Date of Birth: _____ MONTH _____ DAY _____ YEAR
- Medical School: TUHS M.D.? D.O.? (Check One.)
- Country where Medical School located: USA
- Date of Graduation: 6-11-77
- American Specialty Board Certified? (Check If yes.)
Which Boards? OB-Gyn
- Principal Specialty(ies): OB-Gyn, Imaging
- Principal work setting: Diagnostic Ultrasound Associates (office)
- Home address: _____
- Principal business address: 333 Longwood Ave, Boston, MA
- List all hospitals at which you have currently effective privileges: Brigham & Women's
- List all hospitals at which you have held privileges in the past 20 years: MCWP Hospital, St Margaret's
- States other than Massachusetts in which you are presently licensed to practice: None
- List any other states where you were previously licensed to practice: None
- Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? YES NO
- Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
- Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
- Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?
- Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?
- Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
- Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
- Are you now, or have you been in the past, dependent upon alcohol or drugs?
- Have you ever, for any reason, lost American Specialty Board Certification?
- Have you been denied recertification by one or more specialty boards?
If yes, which one(s)?
- I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: Category 1: 60 Category 2: 40
- I am an active inactive practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE. PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

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

Joan E. Lister
 SIGNATURE

DATE: 1-27-87

(See Reverse Side)



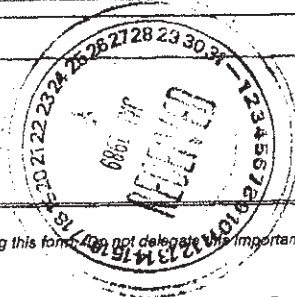
Commonwealth of Massachusetts Board of Registration in Medicine
Tel. West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

003012

Board Use Only:

Registration No. 43434 Status 1 Fee \$150 Renewal Date 03/19/89

JOAN E LISTER
N. ADAMS REGIONAL HOSP.
DR'S. BLDG. HOSPITAL AVE
NORTH ADAMS, MA 01247



M.R. Pr. [Signature] 2/10/89
Bk. [Signature] 3/2/89
Ch. [Signature] 3/2/89
D.E. [Signature] 3/2/89
Fl. [Signature] 3/2/89

Important:

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

1. a) Name (LAST): Lister (FIRST): Juan (M.I.): E

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

2. a) Address (Mailing): Doctors Building, Hospital Ave, North Adams, MA 01247

2. b) Address (Home) _____

2. c) Address (Business): after May 1, 1989: Doctors Building, Hospital Ave, North Adams, MA 01247

2. d) Telephone (Business): (413) 664-4343 Extension _____ 2. e) Telephone (Home) (Optional): _____

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

6. a) Medical School Code (See Table 1): M A D O J # 99999, write Name: _____

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

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

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

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

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

10 Resident or Fellow _____ %	20 Practice involving Direct Patient Care <u>100</u> %	8. b) Mass. Lic. Issue Date (see your wall certificate) (MO/DA/YR): <u>9/21/78</u>
30 Administrative Activities _____ %	40 Medical Teaching _____ %	
50 Medical Research _____ %	99 Other _____ %	

9. Specialty Code (See Table 3): 0 B G Percent of Practice Time: 100 % Specialty Code: _____ Percent of Practice Time: _____ %
If OS, specify: _____

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

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

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. (See Table 4.)
Facility Code: 061 100 % Facility Code: _____ % Facility Code: _____ %
Facility Code: 421 0 % Facility Code: _____ % Facility Code: _____ %
If 999, write Name(s): _____

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. (See Table 4.)
Facility Code: 057 Facility Code: 065 Facility Code: 299 Facility Code: 108 Facility Code: 003
If 999, write Name(s): 999: North Cambridge Community Health Clinic; Preterm; Diagnostic Ultrasound Associates; Boston Imaging, Inc, PC.

* I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.
Pursuant to M.G.L. c.47B, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.
Pursuant to M.G.L. c.82C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state tax returns and paid any Massachusetts state taxes, that are required under law. Note: This applies even if you reside out-of-state or out of the county.
I hereby certify under the penalties of perjury that all information on this form—front and back and (#) attached pages—is true.

Signature: Joan E. Lister Date: 1/16/89

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

Fill in name and number. Physician Last Name: Lister Registration No.: 43434

- 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 *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*
- 14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: (Fill in # of hours or type of residency, or check waiver.)
 Category I: 80 hrs., Category II: 20 hrs., (Risk-Management: 10 hrs.); Residency Program in: _____
 Waiver Requested (You must fill out a separate Waiver Form.)
- 14. b) My medical malpractice insurance is covered by INSURANCE CARRIER LETTER OF CREDIT . *If applicable, check one and identify the name.*
 Insurer: Chubb Papan, De lae/Albos Ins. Corp. Institution Issuing Letter of Credit: _____
 Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one)
 NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how) _____
- 14. c) Percent of Practice Time in Massachusetts: 100 %

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

- 15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
- 16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
- 17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations—See Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?

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

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

- 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?
- 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
- 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
- 21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
- 22. Are you now, or have you been in the past, dependent upon alcohol or drugs?
- 23. Have you, for any reason, lost American Specialty Board Certification?
- 24. Have you been denied recertification by one or more specialty boards? # YES, list Board(s): _____

BOARD OF REGISTRATION IN MEDICINE

ROOM 1507 -- 100 CAMBRIDGE STREET
 BOSTON, MASSACHUSETTS 02202
 RENEWAL APPLICATION
 1986-1988

IMPORTANT -- READ, COMPLETE AND SIGN --

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

SOC SEC NO. OPTIONAL

YOU MUST SIGN BELOW

X

Joan E. Listert
 APPLICANT'S SIGNATURE

SEE REVERSE SIDE

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

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

PLEASE USE THE ENCLOSED RETURN ENVELOPE

NOTE!

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



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

99578

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD		43434	\$100.00	\$100.00	01	15	86	

Joan Listert

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

Joan Listert

DO NOT WRITE BELOW THIS LINE

DO NOT FOLD OR STAPLE THIS FORM

Print Name: Joan Elizabeth Lister

Date of Birth: 1977 6/11/77

Medical School: Tufts

Date of Graduation: 1977 6/11/77

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

- 1. Principal Specialty(ies): Obstetrics & Gynecology
- 2. Principal work setting: HMO
- 3. Home address: same as front
- 4. Principal business address: HCHP - Wellesley Center
230 Worcester St., Wellesley, Mass. 02151
- 5. List all hospitals at which you have currently effective privileges: Brigham & Women's Hospital, HCHP Hospital.
- 6. States other than Massachusetts in which you are licensed to practice: None

	YES	NO
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?		
8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?		
9. Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: Board Certification, Ob-Gyn, 12/7/84; also (a)

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

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE. Joan E. Lister
(YOU MUST ALSO SIGN THE FRONT OF THIS CARD) SIGNATURE

Massachusetts Physician Renewal Application

Physician Name: **JOAN E LISTER**

License No.: **43434**

PART A

1) Current Status: Active

Renewal Due Date: 02/19/2005

Birth Date:

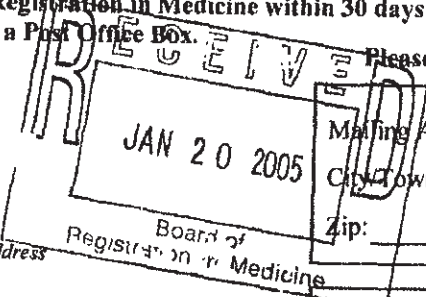
If you want to change your current status, please check one of the following boxes to indicate your new status:
(Check only one). (See Renewal Instructions, page 3.)

- Active
 Retiring
 Inactive
 Do not wish to renew

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

2a) MAILING ADDRESS

Please make corrections (print)



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

Check here to change this address

2b) HOME ADDRESS

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

Home address cannot be a Post Office Box

Phone: (413)458-2691

Check here to change this address

2c) BUSINESS ADDRESS

Ambulatory Care Center
 77 Hospital Ave., Ste 300
 North Adams, MA 01247

Phone: (413)664-4343

Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 413/664-7320

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

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

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

Massachusetts Physician Renewal Application

Physician Name: **JOAN E LISTER**

License No.: **43434**

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

- a) Massachusetts:
- b) Federal (DEA):
- c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

VT _____

8b) States where you were previously licensed (Abbr.)

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

Principal Work Setting: Partnership or Group Practice

Change to: _____

Hours per Week:

~~36~~ 50 45 HL

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

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		# Hours per Week
		Current	Change	
North Adams Regional Hospital	<input type="checkbox"/>	Admitting		<u>4</u>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 436 hrs/wk Change to: 4 hrs/wk
 b) outpatient care 45A hrs/wk Change to: 45 hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: ProMutual Group

Change to: _____

Policy dates: From 04/14/04 To 07/14/05
 (required)

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

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

Check one:

- Not involved with direct or indirect patient care in Massachusetts
- Government Employee Federal Tort Claims Act (FTCA)
- Otherwise exempt (Please explain): _____

Massachusetts Physician Renewal Application

Physician Name: JOAN E LISTER

License No.: 43434

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

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

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

		YES	NO
14) CLAIMS MADE a) <i>New:</i> Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) <i>Pending:</i> 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) <i>New:</i> Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) <i>Resolved:</i> 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) <i>Have any criminal offenses/charges against you been resolved during this time period?</i>			
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?			
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?			
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?			
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?			

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

Massachusetts Physician Renewal Application

Physician Name: JOAN E LISTER

License No.: 43434

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine to access any and all criminal case information on me held by the Massachusetts Criminal History Systems Board.

Signature: _____

Joan E. Lister

Date: 12/22/04

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

Massachusetts Physician Renewal Application

Physician Name: **JOAN E LISTER**

License No.: **43434**

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

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

Principal Work Setting: Partnership or Group Practice

Change to: _____ Hours per Week: ~~36~~ **50** ~~45~~ **42**

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

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		# Hours per Week
		Current	Change	
North Adams Regional Hospital	<input type="checkbox"/>	Admitting		4
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 426 hrs/wk Change to: 4 hrs/wk

b) outpatient care 45 hrs/wk Change to: 45 hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 04/14/04 To 07/14/05

(required)

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

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

Check one:

Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt (Please explain): _____

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

CMK
15-061/07-51
43

PART A

1) Current Status: Active

Renewal Due Date: 02/19/2007

Birth Date:

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

- Active
 Retiring
 Inactive
 Do not wish to renew

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

2a) MAILING ADDRESS

Please make corrections (print)

Check here to change this address

2b) HOME ADDRESS

Phone:

Check here to change this address

2c) BUSINESS ADDRESS

Gynecology Services-Berkshires
2 Park Street
Adams, MA 01220

Phone: (413)743-1263

Check here to change this address

3) E-mail Address: _____

4) Fax Number: 413-664-7320

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JAN 8 1 2007
Board of Registration
In Medicine

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

413-743-0568

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
North Adams Regional Hospital	North Adams,	MA	<input type="checkbox"/>
Berkshire Medical Center	Pittsfield,	MA	<input type="checkbox"/>
Baystate Medical Center	Springfield,	MA	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 4 hrs/wk Change to: _____ hrs/wk

b) outpatient care 45 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: ProMutual Group Change to: Berkshire Insurance Company

Policy dates: From 10/1/06 To 10/1/07

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

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

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

02/01/07 91
57

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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PART C

Check One:

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 11.*)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature: Joan E. Lister

Date: 1/29/07

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

In order for your license to be renewed you must take one of the following actions:

- Option 1:** Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPES web site at www.NPES.cms.hhs.gov.
- Option 2:** Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
- Option 3:** Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
- Option 4:** Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
- Option 5:** If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- My current NPI is:

1	8	2	1	0	4	2	8	2	1
---	---	---	---	---	---	---	---	---	---
- I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- I have applied for an NPI using a third party (enter name): _____ (follow instructions for Option 3)
- By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal Instructions, page 21 for more information). In addition to providing the taxonomy code, please indicate your specialty in the space provided (Taxonomy Description). The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf.

	<u>Taxonomy (Specialty) Code</u>	<u>Taxonomy Description (Print)</u>										
Primary Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td>2</td><td>0</td><td>7</td><td>N</td><td>6</td><td>0</td><td>4</td><td>0</td><td>D</td><td>X</td></tr></table>	2	0	7	N	6	0	4	0	D	X	Ob-Gyn - Gyn
2	0	7	N	6	0	4	0	D	X			
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											_____
Provider Taxonomy:	<table border="1" style="display: inline-table; border-collapse: collapse;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>											_____

NPI REQUIRED INFORMATION

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

Social Security Number:

--	--	--	--	--	--	--	--	--	--

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

Gender: Male Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: Joan E. Lister

Date: 1/29/07

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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268
02/20/09 S1
268

PART A

1) Current Status: Active Renewal Due Date: 02/19/2009 Birth Date: _____

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

Active
 Retiring
 Inactive
 Do not wish to renew

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

2a) MAILING ADDRESS

Check here to change this address

Please make corrections (print)

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

2b) HOME ADDRESS

Phone: (413)458-2691 FEB 19 2009

Check here to change this address

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Gynecology Services-Berkshires
 2 Park Street
 Adams, MA 01220

Phone: (413)743-1263

Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 413-743-0568

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

02/20/09 51 269

(See Renewal Instructions, page 4.)

7) Drug License Numbers

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

Corrections: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

9) States where you were previously licensed

VT _____

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

List the names of all work sites in Massachusetts
(See above and description on page 4.)

Name	Location (City or Town)	State	Delete?
Baystate Medical Center			<input type="checkbox"/>
Berkshire Medical Center			<input type="checkbox"/>
North Adams Regional Hospital			<input checked="" type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

Average weekly hours involved in: a) inpatient care 4 hrs/wk Change to: _____ hrs/wk
 b) outpatient care 45 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: Berkshire Insurance Co.

Change to: _____

Policy dates: From 10/1/08 To 10/1/09

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

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

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)*

Yes No

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

02/20/09 31 271

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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PART C

Check One:

PHYSICIAN PROFILE

- I have reviewed my Physician Profile at <http://profiles.massmedboard.org> and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)
- I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page 11.*)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. As an applicant for renewal of a license to practice medicine, I understand that a criminal record check may be conducted for conviction and pending criminal case information from the Criminal History Systems Board only and that it will not necessarily disqualify me from licensure.

Signature



Date:

2/6/09

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



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

Physician Name: Joan E Lister, M.D.

License No.: 43434

Current Status: Active

License Expiration Date: 3/19/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America

Home Address:

Business Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America
(413) 743-1263

3) Email Address:

4) Fax Number: (413) 743-0568

5) Specialties
Gynecology

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

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

7) Drug License Numbers

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

9) States where you were previously licensed
Vermont

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
Berkshire Medical Center	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

11) Care of patients in Massachusetts

Average weekly hours involved in:

- a) inpatient care 2 hrs/wk
- b) outpatient care 50 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Berkshire Indemnity Company, SPC, Ltd.

Policy Start Date

10/01/2010

Policy End Date

10/01/2011

Policy Type

Claims made with tail coverage

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

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

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

17) Criminal Charges

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

18) Other Issues

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

-
- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

Current Status: Active

License Expiration Date: 3/19/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America

Home Address:

Business Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America
(413) 743-1263

3) Email Address:

4) Fax Number: (413) 743-0568

5) Specialties
Gynecology

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) States where you were previously licensed
Vermont

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
Berkshire Medical Center	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

11) Care of patients in Massachusetts
Average weekly hours involved in:

- a) inpatient care 0 hrs/wk
- b) outpatient care 45 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier
BHS Insurance Co., LTD

Policy Start Date
10/01/2012

Policy End Date
10/01/2013

Policy Type
Claims made with tail coverage

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

14) Claims Made

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

15) Claims Closed

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

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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 you are renewing your license for the first time, please answer Yes) Yes



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

Current Status: Active

License Expiration Date: 3/19/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America

Home Address:

Business Address:
Gynecology Services-Berkshires
2 Park Street
Adams
Massachusetts - 01220
United States of America
(413) 743-1263

3) Email Address:

4) Fax Number: (413) 743-0568

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

9) States where you were previously licensed
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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

11) Care of patients in Massachusetts
Average weekly hours involved in:

- a) inpatient care 0 hrs/wk
b) outpatient care 35 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Berkshire Indemnity Company, SPC, Ltd.	10/01/2014	10/01/2015	Claims made with tail coverage

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

14) Claims Made

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

15) Claims Closed

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

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- 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?



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

- 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?