

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street. 3rd Floor, Boston, MA 02111 (617) 727-3086 http://www.massmedboard.org

Physician Registration Renewal Application

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

Remit	\$250.	00.	for	renewal	fee.

· Add late fee of \$25.00, if necessary.

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

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

alterations as required.	EEDACTED COOK
1. Current Status: Active Registration !	No.: ₄₃₄₃₄ Renewal Date: 03/19/2001
	e of the following boxes to indicate your <u>new</u> 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	Other Name(s): Mailing Address: City/Town: Zip: Country: Business Address: City/Town: State: Zip: Country: Business Telephone: City/Town: State: Zip: Country: Business Telephone: City/Town: State: City/Town: State: City/Town: Country: Howe Telephone: Country: Howe Telephone: Country: Cou
Home Phone:	Zip: Country: Home Telephone: ()
Business Phone:	PLEASE NOTE: No P.O. Box addresses for home or business addresses.
4. a) Date of Birth: b) Sex:	7. Current American Board of Medical Specialties Certification (See Table 2) Of ode: Code:
c) SS#: 5. a) Name of Medical School:	8. Drug License Numbers, if any: a) Federal (DEA):
b) Year Graduated: School of Medicine 1977 C) Degree: M.D.	b) Massachusetts: 9. a) Other states where you are now licensed to practice (Abbr.)
6. Specialty Code(s) (See Table 1) Code(s) Hours per Weck in Mass.	b) States where you were previously licensed (Abbr.)
OBG 0 Obstetrics and Gynccology	
10. Current health care facilities at which you have completed	the credentialing process for the provision of patient care. (Supply ose health care facilities where you have admitting privileges (AP), patient care hours that you provide in each facility).
Facility Code: / (AP) % Facility Code: Facility Code: / (AP) % Facility Code: If 999, print name(s):	/(AP)% Facility Code:/(AP)%/_(AP)% Facility Code:/(AP)%

P	RINT YOUR LAST NAME: LISTER LICENSE NUMBER: 9515		
			F
11	. My medical malpractice insurance is covered by a) M Insurance Carrier b) Letter of Credit		1
	Name of Insurer: <u>Promutual</u> Alternatively, indicate as follows:		
14	am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)		
a)	Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt		
Pl	ease explain exemption:		
12	. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one)	Yes	No.
	. A. What is your principal work setting? (See Table 4) 2		
	B. Care of patients in Massachusetts (see instruction booklet).		
	1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 4 hrs/w	k	
	2) What is the approximate percentage of your patient care hours in primary care? 65%		
PA	ART A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each questi ails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional info Initions. You must answer ALL, questions, or this form will be returned to you and your license renewal may	rmattor	1 200
		YES	NO
14.	<u>CLAIMS MADE</u> : Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
	<u>CLAIMS RESOLVED:</u> Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16.	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
	Have you been charged with any criminal offense, other than a minor traffic violation?		{
	Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20.	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		.
21.	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22.	CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? X Yes		No
	CME Waiver requested (CME waiver form due 30 days prior to date of license expiration)	E exemp	tion
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applicat	ion.	
Pur	suant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule a	nount.	
Pur Vla:	suant to G.L. c. 62C, § 49A, to the best of my knowledge and bellef, I have filed all Massachusetts state tax returns and pai ssachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you reside out-of-state or out of the United	d all I States.	
•	Pursuant to G.L. c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A r withholding and remitting Child Support.	elating t	0
•	Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 5.	! A .	
	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is	true.	
Sier	nature: Apan E. Juliup Date: 1		01
·*5			
	VOI MUST SIGN AND INCLUDE PART B. WITH YOUR RENEWAL APPLICATI	ON	

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

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

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

AS A REGISTERED PHYSICIAN

REGISTRATION NO.

43434

100.00

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.

YOU MUST SIAN BELOW

APPLICANT & SIGNATURE

PAY THIS FEE DATE TO BE RENEWLD LATE FEE

AMOUNT FEE MO DA YR LATE FEE

01

15

DO NOT WRITE BELOW THIS LINE

84

RINT ANY NAME OR ADDRESS CHANGES BELOW

100.00

REGULATIONS.

FEE

PLEASE USE THE END

OF A LITHS APPLICA

JOAN E LISTER

TYPE

LICENSE NUMBER

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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

MT STRUKTORE ON THIS KENEMAL

APPLICATION INDICATES THAT I ATTEST UNDER THE PAINS AND

PENALTIES OF PERJURY TO THE

COMPLIANCE WITH THE BOARD'S

STATUTES AND/OR RULES AND

COMPLETION OF CONTINUING EDUCATION REQUIREMENTS IN

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

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

3500600434340 011584 10000000009

DO NOT FOLD OR TAPLE THIS FORM

CODE

MD

1. Principal Specialty(ies): * 3 0 # 8	2. Principal work setting: * 4 D
3. Home Address:	4. Primary work address: HCHP - Loc/lesley
	230 worcester St, wellesley mass.
5. States other than Massachusetts in which you are license	d to practice: None
6. Has a judgement been returned against you in a malpractice s	yes No suit since 1/15/82?
7. Have you ever been convicted of any criminal offense other that	an minor traffic offenses?
8. Has any disciplinary action been taken against you in this stat	le or any other?
9. Has your privilege to possess, dispense or prescribe controlled in this state or any other?	substances ever been suspended or revoked
10. I have completed my C.M.F. requirements between 1/15/82 &	1/15/84 as follows:* 0 5, 08
FHEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABO *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

• 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: Act DECE WE		
If you want to change your current status, please indicate below: (C	Check one).		
Active Retiring (see instructions)	tive (see below *) Do not wish to renew 3		
2. Other Name(s), if any, under which you were licensed:	Please make corrections (type of print) pistration to the Name(s):		
	Other Name(s):		
3. A) Mailing Home Address:	Mailing Address:		
JOAN E LISTER, M.D.	City/Town: State:		
	Zip: Country:		
B) Business Address:	Other Address:		
DOCTORS BUILDING HOSPITAL AVENUE	City/Town: State: Zip: Country:		
CLARKSBURG, MA 01247	Zip:Country:		
Home Phone:	Home: ()		
Business Phone: (413) 664-4343	Business: ()		
4. A) Date of Birth: Sex: F B) SS#:	Date of Birth: (M/D/Y):/_ Sex: M F SS#:		
5. A) Name of Medical School:	Full Name of Medical School:		
Tufts University School of Medicine			
B) Year Graduated: 1977 C) Degree: MD	Year Graduated: Degree: M.D D.O.		
6. Specialty Code(s) (See Table 1)	Code(s) / Hours Per Week in Massachusetts		
Code(s) Hours per Week in Mass. OBG 60 Obstetrics and Gynecology	<u> 47 N 40 </u>		
The state of the s	If OS, Print Specialty:		
7. Current American Board of Medical Specialties Certification (See Code: OG Code:	Table 2) Code:		
3. Drug License Numbers, if anv:	Federal (DEA):		
A) Federal (DEA): B) Massachusetts:	Mass:		
. A) Other states where you are now licensed to practice			
Abbr:	Abbr:		
B) States where you previously were licensed to practice Abbr:	Abbr:		

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

P	RINT NAME AND NUMBER: Last Name: 15+01 Registration Number: 5	1343	4
l (th	 Current health care facilities at which you have completed the credentialing process for the provision of patient care codes from Table 3 and place a check mark next to those health care facilities where you have admitting privilege ach facility, write the approximate percentage of patient care hours that you provide in each facility. 	are. Supp s (AP). 1	ply Next to
Fa	acility Code: 6 // (AP) /00 % Facility Code: / (AP) % Facility Code: /	(AP)	%
Fa	acility Code:/_ (AP) % Facility Code:/ (AP) % Facility Code:/	(AP)	9/
	999, print name(s):		
11.	. My medical malpractice insurance is covered by a) M Insurance Carrier b) Letter of Credit		
	Name of Insurer: ProMutual Alternatively, indicate as follows:		
I a	m registering with Active status but I am not covered by medical malpractice insurance because I am (check one)		
	Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt		
	ease explain exemption:		
	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ES/N
	A. What is your principal work setting? (See Table 4) 2 0	, [10s	26.1
	B. Care of patients in Massachusetts (see instruction booklet).		
	1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 4 hrs/w	d.	
	2) What is the approximate percentage of your patient care hours in primary care? 60%	'K	
n 4			
	ART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
deta	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each quest alls on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional info	ormation	and
nem	initions. You must answer ALL questions, or this form will be returned to you and your license renewal may	De delay	eq.
		YES	NO
14.	<u>CLAIMS MADE</u> : Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		ļ
15.	<u>CLAIMS RESOLVED:</u> Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		,
17.	Have you been charged with any criminal offense, other than a minor traffic violation?	ł	
	Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
	Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or		
	co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22.	CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? Yes	П .	No
	☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ Training Program	·	
	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applicat		F
	Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedu		nt.
	Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and		
]	Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the U	nited Stat	
	Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119,		
	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is	_	~ ^
igna	ature: Date: 3	18/15	29
,	YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLIC	CATIO	N



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

- 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.
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Registration No.: 43434 Renewal Date: 03/19/9	
1. Activity Status: Active Retiring (s (Check only one) Inactive *(see below) Do not wish 2. Other Name(s), if any, under which you were licensed:	cee instructions) It to renew Corrections (type or print)
	Other Name(s): IN MEDIEVE
3. A) Mailing/Home Address:	Mailing Address:
JOAN E LISTER, M.D.	City/Town: State:
	Zip: Country:
B) Business Address: DOCTORS BUILDING HOSPITAL AVENUE NORTH ADAMS, MA 01247	Other Address: City/Town: Zip: Country:
Home Phone: Business Phone: (413) 664-4343	Home: () Business: () Date of Birth (M/D/Y): / / Sex (M/F):
4. A) Date of Birth: C) Sex: F B) Lic. Issue Date: 09/21/78 D) SS#:	Date of Birth (M/D/Y): / / Sex (M/F):
5. A) Name of Medical School: Tufts University School of Medicine	Full Name of Medical School:
B) Year Graduated: 77 C) Degree: MD	Year Graduated: Degree (MD/DO):
6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. OBG 70 Obstetrics and Gynecology	Code(s) Hours Per Week in Mass. Fig. 16 OS, Print Specialty:
7. Current American Board of Medical Specialties Certificatio Code: OG Code:	
8. Drug License Numbers, if any:A) Federal (DEA):B) Massachusetts:	Federal (DEA):
9. A) Other states where you are now licensed to practice Abbr:	Abbr:
B) States where you previously were licensed to practice Abbr:	Abbr:



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

	Registration Number: Lister Registration Number:	43434
10.	A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Sup Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Facility Code: / (AP) Facility Code: / (AP) Facility Code: Facility Code: / (AP) Facility Code: Facility Code: / (AP) Facility Code: / (
	B. Additional health care facilities at which you previously held privileges or with which you were associated in the past (See Table 3)	lwo (2) years.
	Facility Code: Facili	
11.	If 999, write Name(s): My inedical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit Name of Insurer: b) The surface Carrier b) Letter of Credit	
	Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insura	ince hecause
	I am (check one) a) Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt	aree poetings
	Please explain exemption:	
	Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? (check one)	Yes 🗹 No
13.	A. What is your principal work setting? (See Table 4) 2	
	B. Care of patients in Massachusetts (see instruction booklet).	
	1) Average weekly hours involved in: a) outpatient care 46 hrs/wk b) inpatient care 20 hrs/w	k
	2) What is the approximate percentage of your patient care hours in primary care ? 70 %	
<u>P</u> /	ART A	
det	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each que alls on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in initions.	
IN		
_	THE PAST TWO (2) YEARS:	YES NO
14.	THE PAST TWO (2) YEARS: CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	YES NO
	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or	YES NO
15. 16.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?	YES NO
15. 16. 17.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation?	YES NO
15. 16. 17. 18.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	YES NO
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15. 16. 17. 18. 19. 20. 21.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?	YES NO
15. 16. 17. 18. 19. 20. 21.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? Have you completed your CME requirements preceding your renewal date (see instruction booklet)? Waiver requested (waiver form due 30 days prior to date of license expiration). Training Program exemption	
15. 16. 17. 18. 19. 20. 21.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? Have you completed your CME requirements preceding your renewal date (see instruction booklet)? Waiver requested (waiver form due 30 days prior to date of license expiration). Training Program exemption Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application. RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANS	WERED.
15. 16. 17. 18. 19. 20. 21.	CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? Have you been charged with any criminal offense, other than a minor traffic violation? Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? Have you completed your CME requirements preceding your renewal date (see instruction booklet)? Waiver requested (waiver form due 30 days prior to date of license expiration). Training Program exemption	WERED.

		TER Name Suffi:
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 Ho	spital
Make address corrections here:	Make any corrections to above her	e:
Insurance Plan Affiliation: HMO-Blue, HUHP, CAP, MOST OFFICE BEAL	Licenses Held in Other States:	Accepting New Patients? Yes No
Carriers		Accept Medicaid? Yes No
. EDUCATION & TRAINING	(Please correct as necessary)	
		77
Tufts University School of Medicine Iedical School	MD Degree	Date Date
Iedical School		Daie
edical School ake corrections here		Daie End
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Board of Registration in Medicine

Physician Profile

Final Decisions and orders issued by the Massachus		
<u>Nature</u>	<u>Date</u>	Board Action
•		
HOSPITAL DISCIPLINE		
Hospital	Date	Disciplinary Action
CDIMINAL CONVICTIONS		
CRIMINAL CONVICTIONS The Board of Registration is unable to obtain accurational deliberation in the conviction of fully computations.		
included when the court system is fully computerized of complaint		s. Include conviction date and nature
MALPRACTICE		
Details of claims paid for Dr. LISTER	No. o	f Years in Practice: #
Date Amount Paid 0.0000 Date Amount Paid	Basis for Complaint Basis for Complaint	
Date Amount Paid Date Amount Paid	Basis for Complaint	
Date Amount Paid	Basis for Complaint	
Date Amount Paid	Basis for Complaint	
PHYSICIAN HONORS & PEER-REVIEWE		
Please enter any peer-reviewed publications to which professional recognition you have been given.	a you have contributed and any award	is for community service or
Awards, Honors		Publications
Note: Please return the	survey in the enclosed e	nvelope to:

Board of Registration in Medicine

Physician Profile

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:	Address (Mailing):
JOAN E LISTER, M.D.	City/Town: State: Country: D1267
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 a ability to practice medicine in the Commonwealth. (See enclosed letter	and may affect your FOF Office and in the
· Add late fee if necessary.	
 Make a copy of this form and all attachments for your own records - credentialing and other purposes. The Board will charge a fee for each cop See instructions on detachable coupon at bottom of this page. 	
Pre-Printed Information	Corrections of Pre-Printed Information
Other name(s), if any, under which you were licensed:	Corrections of Fre-Frinzed Information
2. Home Address:	Name: Address: City/Town: State: Country:
3. Date of Birth: Sex: F Lic. Issue Date: 09/21/78 SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Sex (M/F): SS#:
Home Phone Business Phone (413) 664-4343 4. Name of Medical School:	Home: () Business: () Full Name of Medical School:
Tufts University School of Medicine Year Graduated: 77 Degree: MD	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.	Code Hours per Week in Mass.
OBG 70 Obstetrics and Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (S	See Table 2)
Code: OG Code:	Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusens	Federal (DEA): Mass:
 9. Activity Status: I am applying to be registered with the following statu I hereby certify that if requesting Inactive status, I will not practice 	

PRINT NAME AND NUMBER: Physician Last Name: 415+ev Registration Number:	43434
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Sup codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP),	ply the
Facility Code:/(AP) Facility Code:/(AP) Facility Code:/	, ,
Facility Code: /(AP) Facility Code: /(AP) Facility Code: /	— (AP)
If 999, print name(s):	
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in (See Table 3)	•
Facility Code: Facil	ode:
If 999, write name(s):	
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, the List Insurer: Mass. Melli Cul Fro Flosoronal Insurance Association	ck one.
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance became (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: State how otherwise exempt:	ause I am
12. Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow? Yes No (Che	ck one)
13. a) What is your principal work setting? (See Table 4)	
b) Care of patients in Massachusetts (See instruction booklet.) i) How many hours per typical week are you currently involved in outpatient care in Mass? ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)	
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide det Forms R-1 and R-2 for all YES answers. Refer to the instruction bookiet for additional information and definitions.	ails on
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 wi renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.	il be
• Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasona	ble 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 knowled have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This wen 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 re G.L. c. 119, sec. 51A. 	quired by
· 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: Date: 1/20	95

I

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

Registra	tion No. Status Fee Renewal Date Late F 24 ACTIVE \$250.00 03/19/93 \$25.0	Correction of Maning Address:	
Mailing	Address:	Address (Mailing): City/Town: State: Country Code (See Table 1):	-
 Question provide Before provide Make a for creater Enclose 	Staple check to bottom of form. Add late fee if necessarins 1-8 include information from Board files. Please correct as add on the right hand side of the page, proceeding, please read the instruction booklet. Some questions copy of this form and all attachments for your own records dentialing and other purposes. The Board will charge a fee for the \$250.00 renewal fee by means of a certified check, money to the Commonwealth of Massachusetts.	s are optional. s - you will need copies each copy it provides. M.R. FEB I 1003 FFB 1 1003	
Pre-Printe	ed Information	Corrections of Pre-Printed Information	
1. Other n	ame(s), if any, under which you were licensed:		
2. a) Add	ress (Home):	Name: Address (Home): City/Town: State: Zip: Country Code: If 999 print Country:	
5001	tress (Business): FORS ⇒UILDING PITAL AVENUL	Address (Business): City/Town: Country Code: If 999 print Country:	
	TH ADAMS, MA 01247		
Telepho Home	Birth: Sex: f ue Date: 09/21/73 SS#: one Number: Business (413) 554-4343	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:	
Tutt	s University School of Medicine	Year Graduated: Degree (MD/DO):	
Yes	ar Graduated: 77 Degree: MD		一
	r states where you are now licensed to practice (Abbr): s where you previously were licensed to practice (Abbr):	Code Hours per Week in Mass.	
6. Speciali		35 OC miss as said line	_
	on are currently American Specialty Board Certified, enter Code: Code: OG Code:		\exists
pleas	u previously were American Specialty Board certified, but are ne enter codes of prior certification: (See Table 3) Code: Code:	Code: Code:	
8. Drug Li	icense Number(s), if any: a) Federal (DEA) b) State (MA)	Federal (DEA): State (MA):	
You mu	completed my CME requirements in the two years preceding my	by the Board before your license will be renewed. See instructions for	-

Staple Check Here

PRINT NAME AND NUMBER:	Physician Last Name: Lister	Registration Number: 43434
10. Activity Status: I am applying to be regis		
• I hereby certify that if requesting Inacti	ve status, I will not practice medicine, inclu	ding writing prescriptions, in Massachusetts.
List Insurer: JUA: MS	Ed by (a) INSURANCE CARRIER X or ((b) LETTER OF CREDIT If applicable, check one
Alternatively, indicate as follows: I am register	ring with ACTIVE status, but I am not covere	d bur modical malamatic in the state of the
(Check One): (i) NOT INVOLVED IN DIREC	CT/INDIRECT PATIENT CARE IN MASS:_	GO OTHERWISE EYEMPT
12. Current Health Care Facility Affiliations. S	Supply the codes from Table 4 and place a checked Facility Code: / (AP)	ck mark next to those facilities where you have
		Facility Code: / (AP) Facility Code: / (AP)
If 999, print name(s):	The state of the s	(AP)
Additional hospitals at which you previously l (See Table 4.)	held privileges and other health care facilities	with which you were associated in the past 2 years.
If 999, write name(s):		acility Code: Facility Code:
13. Are you currently in a post-graduate training	- A - S	ow? Yes No (Check one)
14. a) What is your principal work setting? (S	see Table 5) 2 0	
11) How many hours per typical week a	re you currently involved in outpatient care in re you currently involved in inpatient care in I	MA? 40 hrs/wk in MA
Questions 15 through 23 refer to the past to Provide details on Form 15A for all YES ar	wo years only. Check either YES or NO (NO aswers. Refer to the instruction booklet for ac	T N/A) to each question. Iditional information.
IN THE PAST TWO YEARS:		YES NO
15. Has any medical malpractice claim been mad		
16. Have you been charged with any criminal off	ense, other than a minor traffic violation?)### ################################
 Have you formally been charged with or disci governmental authority, health care facility. 	plined for any violation of the rules, by-laws or group practice or professional society or associ	or standards of practice of any iation?
18. Has your privilege to possess, dispense or pre- or restricted by any state or federal agency?	scribe controlled substances been surrendered	to or suspended, revoked, denied
19. Have you withdrawn an application for a med		
20. Have you had any mental illness which has im		
21. Have you had an organic illness which has im-		
22. Are you now, or have you been in the past two	years, dependent upon alcohol or drugs?	C. A. D. C.
23. Has any professional liability insurance provide		
• Pursuant to G.L. c. 112, sec. 2, I will not ch	arge to or collect from a Medicare beneficia	ory more than the Medicare reasonable charges.
 Pursuant to G.L. c. 62C, sec. 49A, I hereby filed all Massachusetts state tax returns and paid reside out-of-state or out of the country. 	certify under the penalties of perium, that	to the best of mental and a second
 I hereby certify that I will fulfill my obligate 	ion to report abuse or neglect of children pu	rsuant to G.L. c. 119, sec. 51A.
 I hereby certify under the penalties of perju 	ry that all information on this form and Fo	rm 15A is true.
	Inster, MD	A.3
Signature.	1.11	Date: 2 1/5/9'5



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

A SELV			28272829
Registration No.		Fee Renewal Date	For Office Use Only M.R. Pr. T/D/
		\$150 03/19/91	MR. JIMZ ZILISI
	r. JOAN E		N N N N N N N N N N N N N N N N N N N
	OCTORS BU		
	OSPITAL AN		100 J. S. J.
		S. MA 01247-	WE CO VI
Directions: - Questions 1-7 incli	ude information fro	m Board files. Please correct	the as necessary of the ELZILLOIS pecify which questions are optional.
Before proceeding	, please read the l	nstruction booklet.	A DI DI EI ZI LU
 Answer all non-opt 	tional quastions co	mpletely, (The instructions sp	pecify which questions are opticital.) -you must give health care facilities copies for credentialing purposes. The Board charges
 Make a copy of the \$3.00 plus postage 			-you must give nearn care racinoss copios for cascardainty perpende. The search was gen
• Enclose the \$150.	00 renewal fee by	means of a certified check, mo	oney order or personal check made payable to the Commonwealth of Massachusetts.
Activity Status:			
am applying to be re	egistered with the I	ollowing status: Active	
f hereby c	euith fuut it tedno	seliud iuscriae ererne' i am u	not practice medicine in Massachusetts.
Pre-Printed Informa	ition		Corrections of Pre-Printed Information
1. Other Name(s), i	if anv. under which	vou were licensed;	Name:
		•	
2. a) Address (Home):		Address:
			City/TownZip:
			State:Zip:
m s a a didui i i debirati.	>-		Address: (If 999 write Country):
2. b) Address (Busine			City/Town:
DOCTORS BUTHOSPITAL A			State: Zip:
NORTH ADAM		×47-	State: Zip: Country Code: (if 999, write Country):
Non-			
3. Date of Birth:		Sex: ₽	Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date: Telephone Numi	09/21/78	SSN #:	Lic. Issue Data(NVD/1).
Home	gen.	Business	Home: (Business: ()
()	-	(413)664-4343	
4. Medical School (Code: MAOO7	Year Graduated: 77 Degree	ee: MD School Code: Year Graduated: Degree (MD/DO):
Name of School:			If 99999, write School:
Tufts Ur	niversity	School of Medic	cine —
5. a) Other States wh	tere you are now it	censed to practice (Abbr): icensed to practice (Abbr):	Sample-rend assumptions to the first state of the state o
n) office miles Ao	a previously were i	Controde to breamen (Month	
8. Specialty Code(s	s) (See Table 3):		
	lours per Week in	Mass.	Code Hours per Week in Mass.
0 e G	ado G	tetrics and Gyr	necology — 70
	0	•	
•			If OS, write specialty:
7.a) Ara vou Amaric	an Specialty Board	Certified? (Y/N) y 7.b)	If YES, Enter Codes:
· · · · · ·		of Obstetrics a	1
Code:	, a boar o	01 0230001103	Code:
			Anna Cara Cara Cara Cara Cara Cara Cara C
8. Drug License Nu	imber(s) (if any) [o	ptional]: a) Federal (DEA)	b) How many DEA nos. do you have?
		c) State (MA) #M_	
9. I have complete	d my C.M.E. requi	rements in the two years prece	eding my renewal date: YES Waiver Requested
(You must fill ou	t a separate Waive	r Form. The waiver must be gumentation of your CME's with	granted by the Board before your license will be renewed.) See Instructions for CME
requirements. (mentation of your OME 5 With	[For Office Use Only: Waiver Granted Date: / _ / _]

	ILL IN NAME AND NUMBER: Physician Last Name: L/S +Cr Registration No.: 43 4 3 4	f .
10	D. My medical malpractice insurance is covered by (s) INSURANCE CARRIER or (b) LETTER OF CREDIT. If applicable List Insurer: UHA; CORKING, Perpan, Dilan, & Cellins	, check one.
	Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: (ii) OTHERWISE EXEMPT:	I am (Check one):
	(State how otherwise exampt):	
11.	. Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting pl	ivileges (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 <u>previously</u> held privileges and other Health Care Facilities with which you were associated in the past 4 (See Table 5.) Facility Code: 921 Facility Code: 57 Facility Code: Facilit	years.
	Il 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 or b) If you are in a MA program, are you a l) 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.	e.)
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) 2 D	
Que	and an administration of the standard control of the s	
	estions 15 through 22 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details on Fo or to the instruction booklet for additional information.	rm 18 A.
Ref	er to the instruction booklet for additional information.	Yes No
Ref.	er to the instruction booklet for additional information. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?	Yes No
15. 16. 17. 4	er to the instruction booklet for additional information.	Yes No
15. 16. 17. 4	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	Yes No
15. : 16. : 17. :	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? 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)?	Yes No
15. 16. 17. 4 18. 1	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	Yes No
15. 16. 17. 4 18. 1 19. 1 20. 1	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? 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)?	Yes No
15. 16. 17. 4 18. 1 19. 1 20. 1 21. 1	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? 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)?	Yes No
15. 16. 17. 4 18. 1 19. 1 20. 1 22. 1 Pura	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	Yes No
15. : 16. : 17. : () () () () () () () () () (Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	Yes No
15. 16. 17. 4 18. 19. 1 20. 1 22. 4 Pura tax 1 00001	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense? 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)?	Yes No
15. 16. 17. 6 18. 18. 19. 1 20. 1 22. 7 Pura tax 1 cooul l cer	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations	Yes No
15. 16. 17. 6 18. 18. 19. 1 20. 1 22. 7 Pura tax 1 cooul l cer	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? 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)?	Yes No

BOARD OF REGISTRATION IN MEDICINE

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

TYPE REGISTRATION NO.

LICENSE NUMBER

CODE

BOG SEG- NUMBER, OPTIONAL	-		لمثا	:	
	1	£.,	1 2	1)	

FEE

DATE TO BE RENEWED

MO DA YR

PAY THIS

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

LATE FEE

THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A \$100 PAY-MENT. A CERTIFIED CHECK OR MONEY

MD	1	43434	\$100	100	03 1	9 87			ORDER IS CHECKS A	PREFERRED. RE ACCEPTAB	PERSONAL LE.
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	JOAN	E LISTER	(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	1987	3				15.	ST STREET, 2n	
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9. Home	e address:		1)-	A		333	3 Long	zwood A	ve, Bo	ston, r	<u>1A</u>
I1. List a	# hospitals at	which you have currently	effective privileges:	Brigh		TWG	mas	1111	بالمر		
I2. List a	ii hospitals et	which you have held privi	leges in the past 20 ye	ears: HCL	HP HC	Spir	al, ≥	* Mara	aret's		
3. State	s other than N	Assachusetts in which yo	u are presently licens	ed to practic	ge: [VD]	1e_			<u> </u>		
14. List a	ny other state	es where you were previou	sty licensed to practic	· Non	e						
										YES .	NO
15. Has a	ny medical m	alpractice claim been mad	te against you in the l	ast ten year	rs (whether	or not a la	awsult was tile	ed in relation to t	he claim)?		
1 6 . Have	you, at any ti	me, been a defendant in ai	ny criminal proceedin	g other than	n minor traf	fic offens	es?	week by say a	overnmentsi		4
autho	ority, by any h	ciplinary charges panding cospital or health care facil to possess, dispense or pr called before or warned by	ity, or by any profess	bstances ev	al association	nended.	revoked, denic	nal, state or toca ed, restricted, su	1) ?		-
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		any mental illness which I						dent of medicin	e?		
		an organic illness which t									
		ave you been in the past, o					,				
23. Have 24. Have	you ever, for you been det	any reason, lost American nied recertification by one	Specialty Board Cer	itication?							-
	, which one(s					follows	C. Lear	11:60	Catego	ry 3:4	0
	e completed r an active	ny C.M.E. requirements in	the two years ending r. (Check One.)	on the rene	SWEI GEIG GS	iotiows;		1		T	
I HEREBY	Y CERTIFY UI	NDER THE PENALTY OF F	PERJURY THAT ALL I	NFORMATIC	ON ON THIS	FORM (F OT FROM	FRONT AND E A MEDICARE	BACK) INCLUDIN BENEFICIARY I	G ATTACHED MORE THAN T	SHEETS IS TAL HE MEDICARE	JE. REASON-
ABLE CH PURSUAI RETURNI	ARGE FOR M NT TO M.G.L. S AND PAID /	c. 62C, § 49A, I CERTIFY ALL STATE TAXES REQUIR	UNDER THE PENALT RED UNDER LAW. PL	IES OF PEF Ease Noti	RJURY THA E: THIS APP	T I, TO M PLIES EV	Y BEST KNOV EN IF YOU BE	VLEDGE AND BE	TATE OF OUT	ILED ALL STATI OF THE COUN	ž TAX TRY.
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						44.1	DATE:/	1-27	-8/		
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(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

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	A.	1989-1991 F	hysician Registra	tion Renewa	Application	on, Page	1012		
Board Use Onl				-					
Registration N 43434	o. Status		ewal Date 9/89	282121	32330.5				
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important:			1	3	N/	17			
Read the according to the can result. Print legibly or Answer all nor Sign the renew Make a copy of Enclose the \$1	it in disciplinary ac type your answers n-optional question val application at th of this form and all 150 ranewal fee by	ction. s. hs (<u>front and back</u> o he bottom of page o attachments for voi	before completing this form) completely—It is one and fill in the numb ir own records—you mild d check, money order of	not adequate er of attached p est give hospitali or personal chec	lo state that the ages in the para and other hea is made payable	ne Board all agraph abou ith care faci le to the Cor	ready has t ve the signal lities copies	he Informat lure, for credent of Massact	ialing purposes. nusetts.
1. a) Name (LA	st:) Liskr			(FIRS	T:)				(M.L.) E
1. b) Other Nan	ne(s), if any, that y	ou were ever licens					1 3 4	53761	
2, a) Address (*	vailing): Doc.for	's Buildir	od under: 72, Hospaila	I Ave, N	Intith Aa	lans,	MAOI	29.7	
2, b) Address (i	difer	Fray 1, 15	189: inc, Dospid	I Aue	Nocth A	A and S	MA'	312117	
2. c) Address (E	Business); <u>↓/(2(_++</u>	013 1741161	(1)(1)	() () ()	1007 17 77	7.1411.	7		
 Date of Birth a) Medical Sc b) Year Grad 	(MO/DA/YR):_ chool Code (See 7 [TRI :betsul	able 1): MAD C	4. Sex: MALE # 99999, write No	FEMALEL	5. Socia	d Security N	io. (Optional)	-9 W
6. d) Country:	U.S. 🔽 Canada_	Code if Other	(See Table 2):	If 999, write N	lame:				
10 Hospl 25 Clinic 40 HMO	te!	te Percent(%) of Pr (1) % % %	15 Private Office 30 Mental Health Ce 45 Educational Instit 60 Plant/Commercia	ution	% % % %	20 Partner 35 Nursing 50 Medica 99 Other	al Society		% % %
10 Resid 30 Admir 50 Medic	ent or Fellow nietrative Activities al Research	% %	K) of Professional Time 20 Practice involvi 40 Medical Teachi 99 Other	ng Direct Patien ng		<u>></u> % _% _%	(4 (1	see your wal MO/DA/YR)	c. Issue Date I certificate) : <u>4/21/78</u>
9. Specialty Co	ide <i>(See Table 3)</i> : :	U DO Percent o	f Practice Time: 100	% Specialty	Code:	_ Percent of	PIACUCO III	ne:	b
		y Board Certified? (V/N) Y 10 b) # YF	S, circle which i	Board(s):				
A) E A E CRS E D E EM E FP E IM E NS E	Board of Allergy & Board of Anesthesi Board of Colon & F Board of Dermatols Board of Emergent Board of Family Pr Board of Internal M Board of Neurologi	Immunology iology Rectal Surgery ogy y Medicine actice ledicine	NM Board of 1 OG Board of 0 OP Board of 0 OS Board of 0 OT Board of 0 PA Board of 1 PA Board of 1 PMR Board of 1	obstetrics & Gyu phthalmology phthalmology pathopedic Surg phthalmology Pathology Pediatrics Physical Medicin	ecology ; ery	PM B PN B R B S B TS B U B	pard of Plas oard of Previourd of Pay oard of Rad oard of Surg oard of Tho oard of Urol	rentive Medi chlatry & Ne iology gery racic Surger ogy	urology
(See Tab Facility C Facility C	le 4.) Code: <u>0 fc l</u> Code: <u>4 2 l</u>	100 % 0 %	Pacility Code:		5		asociated; P allity Code:		
If 999, w	rite Name(s):								
(See Tab Facility C # 999, wi	ode: 057 rite Name(s): 999 agnostic	Facility O North (Ultrasour	eld privileges and other ode: 0 6.5 Facility of ASSOCIA:	nity Code: <u>29</u> mmblinide (5) Bot	9 Facility Idealth Hen Inc	11	. 7 -		6 6 'm
•	•	-	us, i will not practice i Best from a Medicare			edicare :==	sonable ch	arge for my	services.
Purayant to M returns and pa	.G.L. c.62C sec.41	9A, I certify under seetts state taxes,	the penalties of perjuithet are required under the last are required under the last information on the	ry that, to my b or law. Note: T	est knowledge his applies ev	and belief en if you re	, I have filed side out-of	any Mass state or ou	
Signature:	Joan	E. Kish	~	इक्ट स्वप्टन्डट इ.टर्ट)				ate: 1	<u>16,89</u>

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application,	Page 2 of 2
Fill in name and number. Physician Last Name: USACT	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 II ACTIVE, ans	wer questions 14. a) through c). newer 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 ty Category I: 90 hrs., Category II: 20 hrs., (Risk-Management: 10 hrs.); Residency Program in: Waiver Requested (You must fill out a separate Waiver Form.)	pe of residency, or check waiver.)
14. b) My medical maipractice insurance is covered by INSURANCE CARRIER. LETTER OF CREDIT. If applicable, che Insurer (Ink by France). Institution issuing Letter of Credit: Attematively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical maipractice insure NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how)	ance because I am (Check one)
14. c) Percent of Practice Time in Massachusetts: 10 %	
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.
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?,,,,,	OTANIES (COLOR DE LA COLOR DE
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations—See instruction against you by any governmental authority, hospital or other health care facility, or professional medical association (international, state or local)?	a) been taken ational,
If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.	
· ************************************	******
Questions 18 through 24 refer to the gest 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, su have you been called before or been warned by this state or any other jurisdiction including a federal agency?	irrendered, or
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 liness which has impaired your ability to practice medicine or to function as a student of medicine	.67
21. Have you had an organic liness which has impaired your ability to practice medicine or to function as a student of medicine	97
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?	[fg1:;a1ev-**a1e34*B1**a**B;*******
23. Have you, for any reason, lost American Specialty Board Certification?	****************************
24. Have you been denied recertification by one or more specialty boards? If YES, list Board(s):	

ROO	М 1507 STON, М	ISTRATION IN MEDIO 100 CAMBRIDGE STREE ASSACHUSETTS 02202 AL APPLICATION 1986-1988	1' PUI D UNDE BEST STAT		L ON THE REVERSE SIDE OF THIS APPLICATION (SEE
STAPLE THIS FORM CODE CODE	TYPE	NSE NUMBER REGISTRATION NO 43434 AT Listert	PAYTHIS AMOUNT	FEE DATE TO BE RENEWED LATE FEE MO UA YII FEE MO	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

Print Name: Jean Elizabeth lister	
Medical School: TuftS Poate of Birth: You must read the instructions enclosed with this form to answer questions 1-12.	
1. Principal Specialty(ies): Obstatrics & Gynecology 2. Principal work setting: HMD 3. Home addres Same as from 4. Principal business address: MCHP - Welles 230 Warnester St. welles	ley Center sley, Mass. 02/81
5. List all hospitals at which you have currently effective privileges: Brightm & Women's Hospital, IICHP Hospital, 6. States other than Massachusetts in which you are licensed to practice: None	41.19 1 11.31 011.81
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?	YES NO
B. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/63? 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 Cerhfichion, Ob-Cujn, 12/7 12. I am an active	7/84; also (a)

Massachusetts Physician Renewal Application Physician Name: JOAN E LISTER License No.: 434

License No.: 43434

PART A			
1) Current Status: Active R	enewal Due Date: 02/19/	2005 Birth Date	
If you want to change your current state (Check only one). (See Renewal Instr	is, please check one of the		<u>new</u> status:
☐ Active ☐ Retiring	☐ Inactive	☐ Do not wish to r	enew
2) Addresses & Contact Information. Please or required to notify the Board of Registration is Business addresses CANNOT be a Post Office.	Negicine within 30 da	and make changes, if necessary. ys of any change of address. However, ase make corrections (print)	You are me and
Sal MAIDING ADDRESS	TE TO	Address:	
	2003 9194	wn:	State:
Check here to change this address	Board of Zip:	Country:	
2b) HOME ADDRESS		Address:	
	City/T	own:	State:
		Country:	
Phone: (413)458-2691	Home	Telephone: ()	Philippe manager
Check here to change this address	H	ome address cannot be a Post Off	ice Box
2e) BUSINESS ADDRESS Ambulatory Care Center	Busine	ss Address:	
77 Hospital Ave., Ste 300	1	own:	State:
North Adams, MA 01247	Zip:	Country:	
Phone: (413)664-4343	Busine	ss Telephone: ()	
Check here to change this address		Susiness address cannot be a Post	
3) E-mail Address:			
1) Fax Number: 413/614-7320			
Specialties (See Renewal Instructions, page 4.	Delete? Ad	ditional specialties:	
Obstetrics and Gynecology	0		<u> </u>
	0		
	0		
) Current American Board of Medical Special See enclosed instructions and Renewal Instructio	ties (ABMS) or America	n Osteopathic Association (AOA	A) Information.
list Certifying Board(s) below:	Update Gener below. Please	al Certificates and Subspecialty add additional Certifications as	Certificates
Board Name ABMS or A			-
bstatrics + Cryner stugy 10 0	Obstetrics & G		
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Massachusetts Physician Renewal Application

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Physician Name: JOAN E LISTER License No.: 43434 (See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers, if any: 8a) Other states where you are now licensed to practice (Abbr.) a) Massachusetts: b) Federal (DEA): 8b) States where you were previously licensed (Abbr.) c) Federal (DEA) XS: 9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Partnership or Group Practice Hours per Week: 36 5045 31 Change to: 10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary. No Affiliations Health Care Facility (See Renewal Instructions, page 4.) Staff Category # Hours Delete? Current Change per Week North Adams Regional Hospital Admitting 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Average weekly hours involved in: a) inpatient care 4.36 hrs/wk Change to: 4 hrs/wk b) outpatient care 45 N 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 TOM 114/05 (required) Letter of Credit subject to Board approval (attach a copy) l 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.: 13) Do you perform any surgery in your office? (See Renewal Instructions, page 5.) Yes No If Yes, please complete Form PCA-O "Office Based Surgery" In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. (See Renewal Instructions, page 5 You must check either YES or NO to each question. Provide details on Form R if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions. ALL questions in this section must be answered. YES NO 14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated? 15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period? 16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? 17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period? 18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? 19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? 22) CME CERTIFICATION: a) Have you completed your CME requirements preceding your renewal date? b) If no, are you requesting a CME waiver? Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to

your license expiration date. (See Renewal Instructions, page 8.)

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

Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: JOAN E LISTER License No.: 43434

DETUCKO	1 2.7	Dec
THISICI.	$\mathbf{A}\mathbf{N}$	PROFILE

I have reviewed my Physician Profile at profiles, mass medboard, 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:

Date: 12 120 104

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

Page 5 of 5

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Massachusetts Physician Renewal Application Physician Name: JOAN E LISTER

- ASSESSED VALUE BOAR E LISTER			LJ	ense No.: 43434	
(See Renewal Instructions, page 4.) 7) Drug License Numbers, if any: a) Massachusetts: b) Federal (DEA). c) Federal (DEA) XS:	8a) Other	r states v	· · · · · · · · · · · · · · · · · · ·	sary now licensed to pr iously licensed (Al	
9) What is your principal work setting? (See Renewal Principal Work Setting: Partnership or Group Practi	ice			Week: 36 B	045 XI
10) List all current health care facilities where you are provision of patient care. (Supply the name of the healthstruction booklet). Next to each facility, write your Associate or Consulting), and the approximate number Include any affiliations with on-line prescribing service facilities on a separate sheet, if necessary.	alth care fa r staff cate _l er of hours	cility fro gory at t of naties	completed the om Reference hat facility (A)	credentialing pro Table 5 on Page 10 dmitting, Active, C	ocess for the 6 of the Courtesy,
No Affiliations					
Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Current	Category Change	# Hours per Week
North Adams Regional Hospital			Admitting		4
1					
			· · · · · · · · · · · · · · · · · · ·		

11) Care of patients in Massachusetts (See Renewal Inst	ructions, p	age 4.)			
Average weekly hours involved in: a) inpatient care b) outpatient care	4 <u>36</u> hr	s/wk	Change to:		
12) Medical Liability Insurance Information (See Rener	wal Instruct	tions par	pe 5)		
My medical liability insurance is provided through: (cl	heck оле)	, pu	,,,,		
Insurance Carrier (complete below)					
Current Insurance Carrier: ProMutual Group		Ch	ange to:		
Policy dates From 04/14/04 Toff (required)	114/02	S			
Letter of Credit subject to Board approval (attack	и а сору)				
☐ I am registering with Active status but I am not r	equired to	have mo	dical liability	insurance because	lam:
Check one: ☐ Not involved with direct or inc ☐ Government Employee Federa ☐ Otherwise exempt (Please exp	direct patier Il Tort Clair	nt care in ms Act (F	Massachusetts		

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D. License No.: 43434 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. Please make corrections (print) 2a) MAILING ADDRESS Mailing Address: RECEIVED City/Town: _____ State: _____ Zip: _____ Country: ____ Check here to change this address Board of Registration 2b) HOME ADDRESS In Medicine Home Address: Zip: Country: ____ Home Telephone: (___)____ Phone: Check here to change this address Home address cannot be a Post Office Box 2c) BUSINESS ADDRESS Business Address: Gynecology Services-Berkshires 2 Park Street City/Town: State: Adams, MA 01220 Country: Business Telephone: (___)___ Phone: (413)743-1263 Check here to change this address Business address cannot be a Post Office Box Correct your E-mail and Fax Number below: 3) E-mail Address: 413-664-7320 4) Fax Number: 5) Specialties (See Renewal Instructions, page 4.) Delete? List Additional Specialties: Obstetrics and Gynecology 6) Current American Board of Medical C-

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	
			П
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Massachusetts Physician Renewal Application Physician Name: Joan E Lister, M.D. License No. 432

License No.: 43434 (See Renewal Instructions, page 4.) Please make corrections as necessary 7) Drug License Numbers Corrections: 8) Other states where you are now licensed to practice a) Massachusetts: b) Federal (DEA): 9) States where you were previously licensed c) Federal (DEA) XS: 10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary. List the names of all work sites in Massachusetts Location State Delete? (See above and description on page 4.) (City or Town) North Adams Regional Hospital MA Berkshire Medical Center Baystale Mexical Center 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 _ 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) Change to: Berkshire Insurance Company Current Insurance Carrier: ProMutual Group 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

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

	YES	NO
14) CLAIMS MADE	1	********
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?		,
6) 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?		
7) 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?		
) 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?		
Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?	-	
Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
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?	***************************************	***************************************
) CME CERTIFICATION:		
a) Have you completed your CME requirements preceding your renewal date? Yes No		
b) If no, are you requesting a CME waiver?		
A CME waiver request form must be submitted at least 30 days prior to your license expiration date. c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)		
CME EXEMPTION: (check one)		

Massachusetts Physician Renewal Application Physician Name: Joan E Lister, M.D. License No.: 43434 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.

OHC:

CERTIFICATIONS

My status is Inactive and I do not have a Physician Profile. (See Renewal Instructions, page 11.)

- 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,
- 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,
- 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
- 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: 1 29 107

MAKE & 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. NATIONAL PROVIDER IDENTIFIER (NPD) 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 of the NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs of the NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs of the NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs of the NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs of the NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs of the NPI will replace all other identifiers assigned to health care providers. and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007. In order for your license to be renewed you must take one of the following actions: Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov. Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org. Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the 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. ☐ 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. Taxonomy Description (Print) Primary Provider Taxonomy: Provider Taxonomy: Provider Taxonomy: NPI REQUIRED INFORMATION In an ongoing effort to improve the quality of the information we collect, please review the following information and make corrections as necessary. Please note: This information is required if you authorize BORIM to apply for an NPI on your behalf. Social Security Number: State of Birth (if US): Country of Birth (if outside the US): ☐ 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.

		of the sementing statute.	
I authorize the Board of Registrat	Authorization for NPI D	<u>Dissemination</u> any authorized hospital, health plan, or	
Signature:	antu _		
MAKE A COPY OF YOUR A	PRI ICATION AND AND	Date: _/_/29_/b7]	; -

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.

02/20/03/50

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1V1aSSaUIIUSCUS	Privsician	Kenewal	Application
Massachusetts)	Trong ar mi	Tabbucanon

Physician Name: Joan E Lister, M.1).		License No.: 43	434
PARTA				
1) Current Status: Active If you want to change your current Check only one: (See Renewal I.	Renewal Due Date status, please check of instructions, page 3.)		Birth Dat boxes to indicate you	e: ar <u>new</u> status:
	eg 🗆 Ina	active	Do not wish to	renew
2) Addresses & Contact Information. Ple required to notify the Board of Registrat Business addresses <u>CANNOT</u> be a Post C	ion in Medicine with	in 30 days of any (changes, if necessary change of address. He corrections (print)	You are
2a) MAILING ADDRESS			orrections (print)	
		City/Town:	Country:	State:
Check here to change this address				
2b) HOME ADDRESS	i	Home Address:		
			Country:	
Phone: (413)458-2691 FEB	1 9 2009 L		:()	
Check here to change this address		Home addre.	ss cannot be a Post O	fice Box
2c) BUSINESS ADDRESS Gynecology Services-Berkshires 2 Park Street Adams, MA 01220		City/Town: Zip:	Country:ne: ()	State:
Phone: (413)743-1263 Check here to change this address	L			
3) E-mail Address:			dress cannot be a Pos	
4) Fax Number: 413-743-0568				
5) Specialties (See Renewal Instructions, page	ge 4.) Delete?	List Addition	al Specialties:	
Obstetrics and Gynecology		:	W	
	8			
6) Current American Board of Medical Sp (See enclosed instructions and Renewal Instr	ecialties (ABMS) or uctions, page 4.)	American Osteopa	athic Association (AC	OA) Information.
List Certifying Board(s) below:	Update General Ce below. Please add a	ertificates and Sub additional Certific	specialty Certificates ations as required.	
Board Name ABMS or AOA	Certificate/Subspec			Delete?
Obstetrics & Gynecology ABMS	Obstetrics and Gyne	cology		
	`.			

Massachusetts Physician Renewal Application Physician Name: Joan E Lister, M.D. License No.: 434

Physician Name: Joan E Lister,	M.D.	License .	No.: 43434	
(See Renewal Instructions, page 4.) 7) Drug License Numbers a) Massachusetts: b) Federal (DEA): c) Federal (DEA) XS:	Corrections:	Please make corrections as 8) Other states where you 9) States where you were p	are <u>now</u> licensed	
10) List all work sites in Massach offices, clinics, nursing homes, etc page 18 of the Renewal Instruction or companies. Please provide all in List the names of all work sites in Mas	n booklet. Includent on booklet. Includent of ormation on all	the health care facilities, refer	to Reference T pased prescribing sheet, if necess	able 4 on
(See above and description on page 4.)		(City or Town)	State	Delete?
Baystate Medical Center				
Berkshire Medical Center				
North Adams Regional Hospital				X
		- 1- 10 - 10 - 10 - 10 - 10 - 10 - 10 -		<u> </u>
				<u> </u>
11) Care of patients in Massachusetts (Average weekly hours involved in: a) b)	inpatient care outpatient care 4	4 hrs/wk Change to:		
12) Medical Liability Insurance Inform	ation (<u>See</u> Renewal I	nstructions, page 5.)		
Check one. Locum tenens must list po			ueh:	
Insurance Carrier (complete below	w)			1
Current Insurance Carrier: Berksh	ire Insurance Co.	Change to:		
Policy dates: From 6 /1 /55	To 10/1			
	e with tail coverage y of the certificate of	Occurrence Policy Insurance or the face sheet)		
Letter of Credit subject to Board				
☐ I am registering with Active statu Check one: ☐ Not involved ☐ A Government	s but I am not requi- with direct or indirect on Employee under Fe	red to have medical liability insura t patient care in Massachusetts deral Tort Claims Act (FTCA)		n:
13) Do you perform any surgery in your If Yes, please complete Form PCA	Massachusetts offic -O "Office Based Sur	e? (<u>See</u> Renewal Instructions, page 5 gery" Form on page 8.	yes Yes	No

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Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D.

License No.: 43434

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?		
practice, employer or professional association?		İ
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?		\dashv
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		
22) CME CERTIFICATION:		
a) Have you completed your CME requirements preceding your renewal date? Yes No		
b) If no, are you requesting a CME waiver?		
A CME waiver request form must be submitted at least 30 days prior to your license expiration date.		
c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)		
CME EXEMPTION: (check one)		

Massachusetts Physician Renewal Application

Physician Name: Joan E Lister, M.D. License No.: 43434

PART C

Check One:

PHYSICIAN PROFILE

M	I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate
	(Please note that it 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,
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 et seq. 1 understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

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

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

Page 5 of



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)

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

Berkshire Medical Center

Location

Page 1 of 4 Date: 1/24/2011 Time: 8:58 AM



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

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

17) Criminal Charges

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

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

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

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

18) Other Issues

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

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

d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

- 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?
- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Page 2 of 4 Date: 1/24/2011 Time: 8:58 AM



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

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

Page 3 of 4 Date: 1/24/2011 Time: 8:58 AM



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)

ABMS/AOA ABMS

Board Name

Obstetrics & Gynecology

Certification

Subspecialty

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

Berkshire Medical Center

Location

Page 1 of 5 Date: 1/29/2013 Time: 2:52 PM



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?

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

b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice

17) Criminal Charges

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

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

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

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

18) Other Issues

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

b) Have you ever taken a leave of absence from any health care facility, group practice or employer?

- c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
- d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?
- 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?
- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Page 2 of 5 Date: 1/29/2013 Time: 2:52 PM



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

Yes

Page 3 of 5

Date: 1/29/2013

Time: 2:52 PM



License No.: 43434

Physician Name: Joan E Lister, M.D.

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

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

Page 4 of 5 Date: 1/29/2013 Time: 2:52 PM



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:

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5) Specialties Gynecology

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

ABMS/AQA

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

Berkshire Medical Center

Location

Page 1 of 5 Date: 1/27/2015

Time: 3:21 PM



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

Berkshire Indemnity Company, SPC, Ltd.

Policy Start Date 10/01/2014

Policy End Date

Policy Type

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?

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

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

17) Criminal Charges

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

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

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

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

18) Other Issues

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

b) Have you taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?

c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?

d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

- 19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by or surrendered to any state or federal agency?
- 20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?
- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?

Page 2 of 5 Date: 1/27/2015 Time: 3:21 PM



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

Page 3 of 5 Date: 1/27/2015 Time: 3:21 PM



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?

Page 4 of 5 Date: 1/27/2015 Time: 3:21 PM