MAR 19 2010
Board of Registration in Medicine

REDACTED COPY

Application #: 243646
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

Legal Name (do not use nicknames or initials, unless they are part of your legal name)

Braaten | Kari | Patricia | | |
Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☒ Other degree MPH ☐ Male ☒ Female

Other Name(s) Used - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Entire Last Name (type or print clearly) | First | Middle | Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: Oslo (City) Norway (State/Province/Territory / Country if not USA)

*Mailing Address: _____ (Number and Street) Telephone: _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Home Address: _____ (Number and Street) Telephone: _____

_____ (City) _____ (State/Province/Territory) _____ (Zip (or postal) Code)

Business Address: 75 Francis Street (Number and Street) Telephone: 617-732-5500

Boston (City) MA (State/Province/Territory) 02115 (Zip (or postal) Code)

E-mail Address: _____ Fax number: 617-277-1440

Are you applying for licensure through FCVS? (See instructions page 12) ☐ Yes ☒ No

*** The Board will use your Mailing Address for all correspondence**

CK.# 1977489
03/22/10
WS

PRINT NAME: Kari Braaten PAGE 2 OF 5

Pre-medical School

			From	To
Facility: Yale University	Degree: BA		8/26/96	5/22/2000
Street: 1 Prospect St	City: New Haven	State: CT		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: Northwestern University	Degree: MD/MPH		8/31/01	5/20/05
Street: 303 E. Chicago Ave.	City: Chicago, IL	State: IL		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 05 / 20 / 2005
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

			From	To
Facility: Brigham & Women's/Mass General	Position: PGY 1-4		6/20/05	6/19/10
Street: 75 Francis St	City: Boston	State: MA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

PRINT NAME: Kari Braaten

Pre-medical School

				From	To
Facility: Yale University	Degree: BA			8/26/96	5/22/2000
Street: 1 Prospect St	City: New Haven	State: CT			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Medical School

				From	To
Facility: Northwestern University	Degree: MD/MPH			8/28/01	5/20/2005
Street: 303 E. Chicago Ave	City: Chicago	State: IL			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Date of medical school graduation: 5 / 20 / 2005
Month Day Year

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

Postgraduate Education:

List all postgraduate training in chronological order from medical school to the present. Include the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

				From	To
Facility: Brigham/Womens/MassGeneral	Position: PGY1			6/18/05	10/31/05
Street: 75 Francis St	City: Boston	State: MA			
Facility: Brigham&Womens/Mass General	Position: PGY1-4			6/20/06	6/18/2010
Street: 75 Francis St	City: Boston	State: MA			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I	6/12/2003	☒ P	☐ F	1
USMLE Step II	3/21/2005	☒ P	☐ F	1
USMLE Step III	6/6/2007	☒ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	(State of examination)	☐ P	☐ F	

PRINT NAME: Kari Braaten

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		

1. List other states (abbreviations) where you are currently or have ever had a full license: _____ _____ _____
2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No
3. List Board Certification(s): _____ Certification date: __/__/__
   _____ Certification date: __/__/__
4. List your practice specialt(ies) Obstetrics and Gynecology
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: I am beginning a fellowship in Family Planning, and plan to then practice OB/Gyn
7. Name of Facility: Brigham and Women's Hospital
   Address: 76 Francis Street City: Boston
8. Anticipated starting date in Massachusetts: 7 / 1 / 2010

Under the penalties of perjury, I declare that I have examined this full 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 a full 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.

Braaten
Signature of Applicant

3 / 17 / 2010
Month Day Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

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

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is: 1 2 4 5 3 6 6 6 2 4

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.

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 3/17/2010

PRINT NAME: Kari Braaten

Hospital Affiliations and Employment

List hospital appointments, in chronological order, where you had active staff privileges. Include the name and address of the facility, your position and dates of affiliation. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

		From	To
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		
Facility: _____ Position: _____		__/__/__	__/__/__
Street: _____ City: _____	State: _____		

1. List other states (abbreviations) where you are currently or have ever had a full license: _____ _____ _____

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No

3. List Board Certification(s): _____ Certification date: __/__/__
   _____ Certification date: __/__/__

4. List your practice specialt(ies) _____

5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

6. Reason for requesting a Massachusetts medical license: I am beginning a fellowship in Family Planning, and plan to then practice ObGyn

7. Name of Facility: Brigham and Women's Hospital
   Address: 76 Francis Street City: Boston

8. Anticipated starting date in Massachusetts: 7 / 1 / 2010

Under the penalties of perjury, I declare that I have examined this full 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 a full 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 of Applicant

3 / 17 / 2010
Month Day Year

(Continued on page5)

CURRICULUM VITAE

PART I: General Information

DATE PREPARED: March 17, 2010

Name: Kari Patricia Braaten, MD, MPH

Office Address: Department of Obstetrics and Gynecology
Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115

Home Address:

E-Mail:

Place of Birth: Oslo, Norway

Education:

8/2001-5/2005 MD	Feinberg School of Medicine, Northwestern University, Chicago, IL
8/2001-5/2005 MPH	Northwestern University, Chicago, IL
8/1996-6/2000 BA	Women's Studies, Yale University, New Haven, CT

Post-doctoral training:

6/2006-6/2010	Obstetrics and Gynecology Residency Brigham and Women's & Massachusetts General Hospitals, Boston, MA

Licensure and Certification:

2006-present	Limited License Commonwealth of Massachusetts Board of Registration in Medicine

Professional Societies:

2005-present	NARAL Pro-Choice America
2005-present	NARAL Pro-Choice Massachusetts
2006-present	American College of Obstetrics and Gynecology, Junior Fellow
2009-present	Massachusetts Medical Society

Awards and Honors:

2009-present	Administrative Chief Resident Brigham and Women's Hospital/Massachusetts General Hospital Integrated Residency in Obstetrics and Gynecology (44 residents)

2008	Pitcher-Garrett Award: support for travel to Norway to investigate healthcare delivery and family planning services in a national healthcare system.
2007	Harvard Medical Students Teaching Award, Obstetrics and Gynecology, Brigham and Women's Hospital
2004	Alpha Omega Alpha
2003-2005	Clerkship Honors: Medicine, Surgery, Obstetrics and Gynecology, Psychiatry, Primary Care, Emergency Medicine, Maternal-Fetal Medicine, Rehabilitation and Physical Medicine. Northwestern University Feinberg School of Medicine, Chicago, IL
2000	Steere Prize for Best Women's Studies Senior Essay Yale University, New Haven, CT

Committees/Organizations:

2009-present	Resident Education Committee Brigham and Women's/Massachusetts General Integrated Residency in Obstetrics and Gynecology
2007-present	Boston Area-Wide Family Planning Group
2001-2005	Medical Students for Choice
2001-2005	American Medical Women's Association

PART II: Research, Teaching and Clinical Contribution:

Teaching of Students in Courses

2006-present	Obstetrics and Gynecology Clerkship, Harvard Medical School: Formal and informal teaching including Gynecology morning rounds, OB chief morning rounds and surgical teaching Brigham and Women's Hospital and Massachusetts General Hospital
2005	Physical Diagnosis course: Medical Student Teaching Assistant Northwestern University Feinberg School of Medicine

Formal Teaching and Presentations

2009	Late Pregnancy Termination; Legal and Ethical Issues Ob/Gyn Grand Rounds, Brigham and Women's Hospital
2008	Controversies in Contraception: does BMI matter? Ob/Gyn Grand Rounds, Brigham and Women's Hospital
2008	Heterotopic pregnancy Gynecology Conference, Brigham and Women's Hospital

2007	Uterine Perforation Associated with Pregnancy Termination Gynecology Conference, Brigham and Women's Hospital
2007	Not Your Average Ectopic: Ovarian Ectopic Pregnancy Ob/Gyn Grand Rounds, Massachusetts General Hospital Ob/Gyn Grand Rounds, Salem Hospital
2005	Pain Management in First-Trimester Abortion Ob/Gyn Grand Rounds, Massachusetts General Hospital

Research Activity

2008-present	IUD malpositioning: risk factors, outcomes and future pregnancies Case control study Poster accepted for presentation at Association of Reproductive Health Professionals annual meeting 2009
2006-present	Fetal movement in pregnancies with liveborn infants Cross-sectional survey of postpartum women at BWH/MGH Project ongoing
2002	Correlation between personality profiles and satisfaction surveys of women undergoing medical and surgical abortion Study design and IRB submission Northwestern University Feinberg School of Medicine

Education of Patients and Service to the Community

2005-present	NARAL Pro-Choice Massachusetts Participation in advocacy events
1998	Anti-Sexual Abuse Project Performer, presenter and teacher to high school and college students

Previous Employment

2005-2006	Quality Assurance Associate Planned Parenthood League of Massachusetts
2005-2006	Research Assistant Division of Urogynecology Brigham and Women's Hospital
2005-2006	Research Associate and Interventionist Department of Psychiatry Brigham and Women's Hospital
2000-2001	Health Education Coordinator

American Heart Association – Rocky Mountain Division

1999-2000 Health Education and Marketing Intern
Planned Parenthood of Connecticut

PART III: Bibliography

1. Braaten, KP. The abortion counseling service Jane; its public health significance [Masters thesis]. Chicago (IL): Northwestern Univer.: 2005.

2. Braaten KP, and Laufer MR. Human Papillomavirus (HPV), HPV-related disease, and HPV vaccine. Reviews in Obstetrics and Gynecology 2008;1;1: 2-10.

3. Braaten K, Briegleb C, Hauke S, Niamkey N, Chang, G. Screening Pregnant Young Adults for Alcohol and Drug Use: A Pilot Study. Journal of Addiction Medicine 2008; 2:74-78.

4. Shah AD, Massagli MP, Kohli N, Rajan SS, Braaten KP, Hoyte L. A reliable and valid instrument to assess patient knowledge about urinary incontinence and pelvic organ prolapse. International Urogynecology Journal Including Pelvic Floor Dysfunction 2008; 19(9):1283-9.

CURRICULUM VITAE

PART I: General Information

DATE PREPARED: March 17, 2010

Name: Kari Patricia Braaten, MD, MPH

Office Address: Department of Obstetrics and Gynecology
Brigham and Women's Hospital
75 Francis Street
Boston, MA 02115

Home Address:

E-Mail:

Place of Birth: Oslo, Norway

Education:

2001-2005	MD	Feinberg School of Medicine, Northwestern University, Chicago, IL
2001-2005	MPH	Northwestern University, Chicago, IL
1996-2000	BA	Women's Studies, Yale University, New Haven, CT

Post-doctoral training:

2006-2010	Obstetrics and Gynecology Residency Brigham and Women's & Massachusetts General Hospitals, Boston, MA

Licensure and Certification:

2006-present	Limited License Commonwealth of Massachusetts Board of Registration in Medicine

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2005-present	NARAL Pro-Choice Massachusetts
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2008	Heterotopic pregnancy Gynecology Conference, Brigham and Women's Hospital

2007	Uterine Perforation Associated with Pregnancy Termination Gynecology Conference, Brigham and Women's Hospital
2007	Not Your Average Ectopic: Ovarian Ectopic Pregnancy Ob/Gyn Grand Rounds, Massachusetts General Hospital Ob/Gyn Grand Rounds, Salem Hospital
2005	Pain Management in First-Trimester Abortion Ob/Gyn Grand Rounds, Massachusetts General Hospital

Research Activity

2008-present	IUD malpositioning: risk factors, outcomes and future pregnancies Case control study Poster accepted for presentation at Association of Reproductive Health Professionals annual meeting 2009
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2. Braaten KP, and Laufer MR. Human Papillomavirus (HPV), HPV-related disease, and HPV vaccine. Reviews in Obstetrics and Gynecology 2008;1;1: 2-10.

3. Braaten K, Briegleb C, Hauke S, Niamkey N, Chang, G. Screening Pregnant Young Adults for Alcohol and Drug Use: A Pilot Study. Journal of Addiction Medicine 2008; 2:74-78.

4. Shah AD, Massagli MP, Kohli N, Rajan SS, Braaten KP, Hoyte L. A reliable and valid instrument to assess patient knowledge about urinary incontinence and pelvic organ prolapse. International Urogynecology Journal Including Pelvic Floor Dysfunction 2008; 19(9):1283-9.

Full License Applicat

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: KBraaten Date of Birth ____

Print or Type Name: Braaten (Last name) Kari (First Name) P (Middle Initial) Social Security No: ____

Other Name(s) ____ (Please type or print name(s))

Name of Medical School: Northwestern University Feinberg School of Medicine

Address: 303 E. Chicago Ave City: Chicago State or Province: IL

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it to the Board of Registration in Medicine.

APPLICANT'S EDUCATIONAL HISTORY

If name of institution was different from the above named institution when applicant attended, please enter name below:

____

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Yale University

Undergraduate School Address. ____

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Braaten (Last name) Kari (First name) P. (Middle Initial)

(type or print the applicant's name):

attended our medical school on the following dates (indicate the month, day and year in the section below):

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08 / 31 / 01	05 / 24 / 02	07 / 06 / 04	05 / 20 / 05
	08 / 30 / 02	05 / 23 / 03	/ /	/ /
	07 / 07 / 03	05 / 21 / 04	/ /	/ /

The applicant attended 155 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☒ was awarded a degree in Doctor of Medicine on (month/day/year) MAY / 20 / 2005

☐ was NOT awarded degree. Please explain reason(s). _____

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered. If you answer "YES" to any of the questions below, please enclose an explanation.

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Miroslava Rachuy

Print Name: Miroslava Rachuy

Title: Academic Records Assistant

Date: 03 / 29 / 10 Telephone: (312) 503-1225

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: KBraaten Date: 2/9/10

Print or Type Name: Kari Patricia Braaten

Name of Institution: Brigham & Women's Hospital

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Brigham & Women's Hospital

If name of institution was different when applicant attended, please enter name:

Enrollment and Participation: Our records indicate that Kari Braaten (Print applicant's name) participated in the following program:

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	OB/GYN	6/20/05	8/3/05	NO	ACGME
Internship	1	OB/GYN	6/20/06	6/19/07	Yes	ACGME
Residency	2	OB/GYN	6/20/07	6/19/08	Yes	ACGME
Residency	3	OB/GYN	6/20/08	6/19/09	Yes	ACGME
Residency	4	OB/GYN	6/20/09	6/19/10	In progress	ACGME

(Continued on page 2)

APPLICANT'S NAME: Kari P. Braaten

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☑ was accredited by: ☑ ACGME ☐ Other: _____

COMMENTS: _____

Certification: I hereby certify that the above information is correct, to the best of my knowledge.

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: Ruth E Tuomala

Print Name: Ruth E Tuomala

Academic Title: Residency Program Director

Telephone: 617-732-7801 Today's Date: 2, 9, 2010

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

SUPPLEMENT FORM

PRINT NAME: Kari Braaten DATE: 3/17/2010

IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: KBraaten Date: 3/17/2010

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?		
15-B.	In the past ten (10) years, 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 has such a suit been settled, adjudicated or otherwise resolved?		

Applicant's Signature: Brata **Date:** 3/17/2010

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kari P Braaten, M.D. **License No.:** 243646

Current Status: Active **License Expiration Date:** 1/12/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
75 Francis Street
Boston
Massachusetts - 02115
United States of America
(617) 732-5500

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 2 hrs/wk
b) outpatient care 16 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2010	12/31/2010	Claims made with tail coverage
CRICO	01/01/2011	12/31/2012	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

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

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

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

Physician Name: Kari P Braaten, M.D. **License No.:** 243646

Compliance with Legal Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kari P Braaten, M.D. **License No.:** 243646

Current Status: Active **License Expiration Date:** 1/12/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Brigham and Women's Hospital
850 Boylston Street
Chestnut Hill
Massachusetts - 02467
United States of America
(617) 732-9300

3) **Email Address:**

4) **Fax Number:** (617) 525-7746

5) **Specialties**
Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 18 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/15/2012	12/31/2012	Claims made with tail coverage
CRICO	01/01/2013	12/31/2013	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

22) Have you completed all 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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kari P Braaten, M.D. **License No.:** 243646

Current Status: Active **License Expiration Date:** 1/12/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
Brigham and Women's Hospital
850 Boylston Street
Chestnut Hill
Massachusetts - 02467
United States of America
(617) 732-9300

3) **Email Address:**

4) **Fax Number:** (617) 525-7746

5) **Specialties**
Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 1 hrs/wk
b) outpatient care 19 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2014	12/31/2014	Claims made with tail coverage
CRICO	01/01/2015	12/31/2015	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 time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

Physician Name: Kari P Braaten, M.D. **License No.:** 243646

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

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

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