REDACTED COPY

amg

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved: R Deterling
~~Disapproved~~: 5-18-86

Application for Endorsement Registration - NATIONAL BOARDS
(Fee- $150. must accompany APPLICATION - No currency or personal checks)

Filed: 4/24/86
By:
Form of Fee: [illegible]

FOR OFFICE USE

Application # 60745
Certificate # 55906 Date of Issue: 5-28-86

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name: Molly Elizabeth Clark
First Middle Last

Date of Birth

Place of Birth: Albany, New York

Name on Birth Certificate: Same

Mailing Address:

Phone #

Pre-medical Education

School: Smith College

Dates Attended: 1974 - 1978

Medical Education

School: Albany Medical College

Dates Attended: 1978 - 1982.

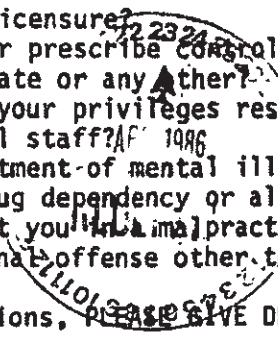
POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

| Place | Position | Dates |
|---|---|---|
| Tufts University Affiliated Hospitals | OBGYN Residency PGY I, II, III, IV | 1982-1986 |

List all other states where you are or have been licensed: None.

Are you a Diplomate of a Specialty Board? No.
(name, if applicable)

| | Yes | No |
|---|---|---|
| 1. Have you ever had any medical license revoked, suspended or cancelled? | | |
| 2. Have you ever been denied a medical license? | | |
| 3. Have you ever been denied the privilege of taking an examination before any State Medical Board? | | |
| 4. Have you ever failed an examination for licensure? | | |
| 5. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? | | |
| 6. Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff? | | |
| 7. Have you ever been a patient for the treatment of mental illness? | | |
| 8. Have you ever been under treatment for drug dependency or alcoholism? | | |
| 9. Has a judgement ever been returned against you in a malpractice suit? | | |
| 10. Have you ever been convicted or any criminal offense other than minor traffic offenses? | | |



If you answered YES to any of the above questions, PLEASE GIVE DETAILS:

POOR ORIGINAL COPY

**BOARD OF REGISTRATION IN MEDICINE**
TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC. NUMBER, OPTIONAL

118203

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

| LICENSE NUMBER | | | PAY THIS AMOUNT | FEE | DATE TO BE RENEWED | | | LATE FEE |
|---|---|---|---|---|---|---|---|---|
| CODE | TYPE | REGISTRATION NO. | | | MO | DA | YR | |
| MD | 1 | 55906 | $100 | 100 | 11 | 18 | 87 | |

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

**PAYABLE TO:**
**COMMONWEALTH OF MASSACHUSETTS**
**TEN WEST STREET, 2nd FLOOR**
**BOSTON, MASSACHUSETTS 02111**

MOLLY E CLARK

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

**YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.**

1. Print Name: Molly Elizabeth Clark M.D.
2. Date of Birth: MONTH DAY YEAR
3. Medical School: Albany Medical College M.D.? ☑ D.O.? ☐ (Check One.)
4. Country where Medical School located: United States
5. Date of Graduation: June 1982
6. American Specialty Board Certified? ☐ (Check if yes.)

   Which Boards?
7. Principal Specialty(ies): Obstetrics & Gynecology
8. Principal work setting: Boston City Hospital
9. Home address: Same as Above
10. Principal business address: Boston City Hospital Maternity Building Hyn-2 818 Harrison Ave Boston
11. List all hospitals at which you have currently effective privileges: Boston City Hospital, University Hospital, Cambridge City Hosp-
12. List all hospitals at which you have held privileges in the past 20 years: Above + St Margaret's Hospital + New England Medical Ctr
13. States other than Massachusetts in which you are presently licensed to practice: None
14. List any other states where you were previously licensed to practice: None.

| | YES | NO |
|---|---|---|
| 15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time? | | |
| 19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason? | | |
| 20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past, dependent upon alcohol or drugs? | | |
| 23. Have you ever, for any reason, lost American Specialty Board Certification? | | |
| 24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)? | | |

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows:
26. I am an active ☑ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

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

Molly Clark M.D.
SIGNATURE

DATE: 11-2-87

**(See Reverse Side)**

17198.0000

## I. PHYSICIAN INFORMATION

| MOLLY | E | CLARK | |
|---|---|---|---|
| *First Name* | *Middle Initial* | *Last Name* | *Suffix* |

*Make changes to name here*

Mass License # 55906

License Status Active

First Issue Date 05/28/86

Women's Health Associate
173 Worcester Street
Wellesley Hils, MA 02181
U.S.A.
(617) 237-0080

**Hospital Affiliation**

Newton-Wellesley Hospital

*Make address corrections here:*

*Make any corrections to above here:*

**Insurance Plan Affiliation:**

Office Accepts most insurance plans. Please call office to verify. JJ

(617) 237-0080

**Licenses Held in Other States:**

*(Please correct as necessary)*

Accepting New Patients? ☑ Yes ☐ No

Accept Medicaid? ☑ Yes ☐ No

## II. EDUCATION & TRAINING

| Albany Medical College of Union University | MD | 82 |
|---|---|---|
| *Medical School* | *Degree* | *Date* |

*Make corrections here*

| Tufts Affiliated OBGYN Program | 1982 | 1986 |
|---|---|---|
| *Residency Program(s)* | *Start* | *End* |
| *Residency Program(s)* | *Start* | *End* |
| *Residency Program(s)* | *Start* | *End* |

## III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

*Make any corrections here:*

## BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

*Make any corrections here:*

## IV. BOARD DISCIPLINE

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

| Nature | Date | Board Action |
| --- | --- | --- |

## V. HOSPITAL DISCIPLINE

| Hospital | Date | Disciplinary Action |
| --- | --- | --- |

## VI. CRIMINAL CONVICTIONS

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

## VII. MALPRACTICE

No. of Years in Practice: # 10

Details of claims paid for Dr. CLARK

| Date | Amount Paid | Basis for Complaint |
| --- | --- | --- |
| ~1986 | 10,0000 — | Unsuccessful Tubal ligation |
| | | |
| | | |
| | | |
| | | |
| | | |

## VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

| Awards, Honors | Publications |
| --- | --- |
| | 4/1985 Obstetrics & Gynecology |
| | Prevention of Group B Strep sepsis |

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

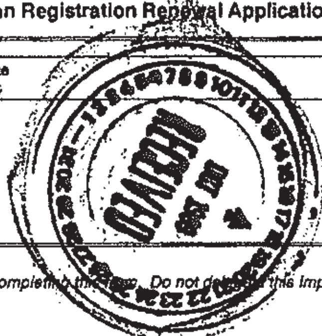
**Commonwealth of Massachusetts Board of Registration in Medicine**
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
**1989-1991 Physician Registration Renewal Application, Page 1 of 2**

018389

**Board Use Only:**

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| [illegible] | | $150 | 11/15/89 |

MOLLY E CLARK



M.R.
Pr. 10/9/89
Bk.
Ch.
D.E. 10/[illegible]
Fl.

**Important:**

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

1. a) Name (LAST:) ________ ,(FIRST:) ________ ,(M.I.:) ________

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

2. a) Address (Mailing): Same As Above

2. b) Address (Home): Same As Above

2. c) Address (Business): The Cambridge Hospital - Room 509
Cambridge, MA 02139

2. d) Telephone (Business): (617) 498-1660 Extension ____ 2. e) Telephone (Home) *(Optional)*: ____

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

6. a) Medical School Code *(See Table 1)*: NY003 *If 99999, write Name*: ____

6. b) Year Graduated: 1982 6. c) Degree (M.D.) D.O. ___

6. d) Country: (U.S.) Canada ___ Code if Other *(See Table 2)*: ___ *If 999, write Name*: ____

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

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

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

| | | | |
|---|---|---|---|
| 10 Resident or Fellow | ___ % | 20 Practice Involving Direct Patient Care | 100 % |
| 30 Administrative Activities | ___ % | 40 Medical Teaching | ___ % |
| 50 Medical Research | ___ % | 99 Other | ___ % |

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): ___/___/___

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 100 % Specialty Code: ___ Percent of Practice Time: ___ %
*If OS, specify*: ____

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

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

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*

Facility Code: 108 100 % Facility Code: ___ ___ % Facility Code: ___ ___ %
Facility Code: ___ ___ % Facility Code: ___ ___ % Facility Code: ___ ___ %

*If 999, write Name(s)*: ____

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: 307 Facility Code: 084 Facility Code: 299 Facility Code: 065 Facility Code: ___

*If 999, write Name(s)*: ____

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

**Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.**

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

**I hereby certify under the penalties of perjury that all information on this form--front and back and (#) ____ attached pages--is true.**

Signature: Molly Elizabeth Clark MD *(see reverse side)* Date: 9/10/89

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

*Fill in name and number.* **Physician Last Name:** Clark **Registration No.:** 55926

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 (circled) INACTIVE___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 190 hrs., Category II: 15 hrs., (Risk Management: 10 hrs), Residency Program in: ______;
Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER X LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer: Joint Underwriters of America Institution issuing Letter of Credit: ______
*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE___ OTHERWISE EXEMPTED___ *(State how)* ______

14. c) Percent of Practice Time in Massachusetts: 100 %

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

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

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

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

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

*****************************************************************************************************

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

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

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

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

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

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

23. Have you, for any reason, lost American Specialty Board Certification? ..........

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* __ __ __ __ __ __ ..........

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

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 55906 | ACTIVE | $150 | 11/15/91 |

Dr. MOLLY E CLARK

**For Office Use Only**

M.R. ________ ___/___/___
Pr. ________ ___/___/___
Bk. ________ ___/___/___
Ch. ________ ___/___/___
D.E. ________ ___/___/___

**Directions:**

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

ENTERED NOV - 4 1991

**Activity Status:**

I am applying to be registered with the following status: Active X Inactive ______

**I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.**

**Pre-Printed Information** | **Corrections of Pre-Printed Information**

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

Name: ______

2. a) Address (Home):

Address: ______
City/Town: ______
State: ______ Zip: ______
Country Code: ______ (If 999 write Country): ______

2. b) Address (Business):

THE CAMBRIDGE HOSPITAL
~~ROOM 509~~
CAMBRIDGE, MA 02139-

Address: ______
City/Town: ______
State: ______ Zip: ______
Country Code: 0 (If 999, write Country): ______

3. Date of Birth Sex: F
Lic. Issue Date: / / SSN #
Telephone Number:
Home Business
(617)498-1660

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): ______
Lic. Issue Date(M/D/Y): ___/___/___ SSN #: ______
Home: (____)______ Business: (____)______

4. Medical School Code NY003 Year Graduated 82 Degree: MD
Name of School:
Albany Medical College of Union University

School Code: ______ Year Graduated: ______ Degree (MD/DO): ______
If 99999, write School: ______

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 3*):

| Code | Hours per Week in Mass. |
|---|---|
| OBG | Obstetrics and Gynecology |

| Code | Hours per Week in Mass. |
|---|---|
| OBG | |

If OS, write specialty: ______

7.a) Are you American Specialty Board Certified? (Y/N) N (Yes)
7.b) If YES, Enter Codes:
Code:
Code:

Code: OG
Code: ______

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA)__
c) State (MA) #M__
b) How many DEA nos. do you have? 1

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

30M - 9/90 - P813971

[For Office Use Only: Waiver Granted ______ Date: ___/___/___ ]

FILL IN NAME AND NUMBER:

Physician Last Name: Clark ______ Registration No.: 55906

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER__ __or (b) LETTER OF CREDIT______. If applicable, check one.

List Insurer:_

*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:
(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:______ (ii) OTHERWISE EXEMPT:______

*(State how otherwise exempt)*:______

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

Facility Code: 108/✓(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)

Facility Code: 168/__(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)

*If 999, write* Name(s):______

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

Facility Code: 307 Facility Code: ___ Facility Code: ___ Facility Code: ___

*If 999, write* Name(s):______

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)
   a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No ✓ (Check one.)
   b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)
   c) How many hours per typical week do you spend in this MA post-graduate training program?______hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)
   a) How many hours per typical week are you currently involved in *outpatient* care in MA?__ hrs./wk. in MA.
   b) How many hours per typical week are you currently involved in *inpatient* care in MA?__ hrs./wk. in MA.

14. Principal Work Setting.
   a) What is your principal work setting? *(See Table 6)*

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

| | Yes | No |
|---|---|---|
| 15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? | | |
| 16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense? | | |
| 17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, nationa state or local)? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs? | | |

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

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

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

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

Signature: Milly Clark MD Date 10 / 27 / 91

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

| Registration No. | Status | Fee | Renewal Date | Late Fee |
|---|---|---|---|---|
| 55906 | ACTIVE | $250.00 | 11/15/93 | $25.00 |

**Mailing Address:**
MOLLY E CLARK, M.D.

**Correction of Mailing Address:**
Address (Mailing): ____________
City/Town: ____________
State: ____________
Country Code (See Table 1): ____________

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

For Office Use Only
M.R. NOV 15 1993
Pr. FP NOV 15 1993
Bk/D.E. ____________

**Pre-Printed Information**

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

2. a) Address (Home):

   b) Address (Business):
   THE CAMBRIDGE HOSPITAL

   CAMBRIDGE, MA 02139

3. Date of Birth: Sex: F
   Lic. Issue Date: / / SS#:
   Telephone Number:
   Home
   Business
   (617)498-1000

4. Name of Medical School:
   Albany Medical College of Union University
   Year Graduated: 82 Degree: MD

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

6. Specialty Code(s) (See Table 2):
   Code Hours per Week in Mass.
   [illegible] Obstetrics and Gynecology

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

8. Drug License Number(s), if any: a) Federal (DEA)
   b) State (MA)

**Corrections of Pre-Printed Information**

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

Date of Birth (M/D/Y): __/__/__ Sex (M/F): ________
Lic. Issue Date (M/D/Y): __/__/__ SS#: ________
Telephone Number:
Home: ( ) ________ Business: ( ) ________
Full Name of Medical School: ____________

Year Graduated: ________ Degree (MD/DO): ________

Code Hours per Week in Mass.

If OS, print specialty: ____________

Code: OG. Code: ________

Code: ________ Code: ________

Federal (DEA): ____________
State (MA): ____________

9. I have completed my CME requirements in the two years preceding my renewal date: (Yes) ________ No, waiver requested ________
You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

**Staple Check Here**

PRINT NAME AND NUMBER: Physician Last Name: Clark Registration Number: 55966

10. Activity Status: I am applying to be registered with the following status: Active ✓ Inactive ___
- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

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

List Insurer: ______________________________

*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:_____ (ii) OTHERWISE EXEMPT: _____
(State how otherwise exempt): ______________________________

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: 1 2 8 / ✓ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)
Facility Code: 1 6 8 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): ______________________________

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

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): ______________________________

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

14. a) What is your principal work setting? (See Table 5) 2 5

b) Care of patients in Massachusetts (MA) (See instruction booklet.)
   i) How many hours per typical week are you currently involved in *outpatient* care in MA? ___ hrs/wk in MA
   ii) How many hours per typical week are you currently involved in *inpatient* care in MA? ___ hrs/wk in MA

Questions 15 through 23 refer <u>to the past two years only.</u> Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. <u>Refer to the instruction booklet for additional information.</u>

**IN THE PAST TWO YEARS:**

| Question | YES | NO |
|---|---|---|
| 15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? | | |
| 18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? | | |
| 19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? | | |
| 22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs? | | |
| 23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage? | | |

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

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

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

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

Signature: Molly Clark MD Date: 11/8/93

# 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 |
|---|---|---|---|---|
| 55906 | ACTIVE | $250.00 | 11/15/95 | $25.00 |

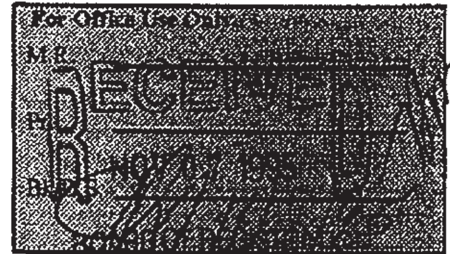
Mailing Address:
MOLLY E CLARK, M.D.

Correction of M

Address (Mailing): ______
City/Town: ______
State: ______
Country: ______

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

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




**Pre-Printed Information**

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

2. Business Address:
THE CAMBRIDGE HOSPITAL
CAMBRIDGE, MA 02139

3. Date of Birth: Sex: F
Lic. Issue Date: 05/28/86 SS#:

Home Phone | Business Phone
(617)498-1660

4. Name of Medical School:
Albany Medical College of Union University
Year Graduated: 82 Degree: MD

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

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

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

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

**Corrections of Pre-Printed Information**

(2) Name: Women's Health Associates
Address:
City/Town:
State: Zip:
Country:

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:

Home: ( ) Business: (617) 237-0080

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code | Hours per Week in Mass.

If OS, print specialty:

Code: Code:

Federal (DEA):
Mass:

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

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

PRINT NAME AND NUMBER: Physician Last Name: Clark Registration Number: 55906.

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

Facility Code: _ 7 5 / ✓ (AP) Facility Code: ___ / __ (AP) Facility Code: ___ / __ (AP)

Facility Code: ___ / __ (AP) Facility Code: ___ / __ (AP) Facility Code: ___ / __ (AP)

If 999, print name(s): ______

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

Facility Code: 1 0 8 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ______

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

List Insura ______

*Alternatively, indicate as follows:* I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___

State how otherwise exempt: ______

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

13. a) What is your principal work setting? (See Table 4) 2 0

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? hrs/wk

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

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) _ %

Questions **14 through 24** refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. <u>Refer to the instruction booklet for additional information and definitions.</u>

**IN THE PAST TWO YEARS:** YES NO

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

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

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

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

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

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

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

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

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

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

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

25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested ___ No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: Molly Elizabeth Clark MD Date: 11/2/95

# Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

# Physician Registration Renewal Application

**Before proceeding, please read the instruction booklet.**

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
  - **Return renewal application in GREEN envelope.**
  - **Enclose check with coupon in BLUE envelope.**

Registration No.: 55906 Renewal Date: 11/15/97

RECEIVED NOV 12 1997 BOARD OF REGISTRATION IN MEDICINE

1. Activity Status: (Check only one) [X] Active [ ] Inactive *(see below) [ ] Retiring (see instructions) [ ] Do not wish to renew

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

3. A) Mailing/Home Address:

MOLLY E CLARK, M.D.

B) Business Address:

~~WOMEN'S HEALTH ASSOCIATE~~
~~173 WORCESTER STREET~~
~~WELLESLEY HILS, MA 02181~~

Home Phone:
Business Phone: ~~(617)237-0080~~

4. A) Date of Birth: C) Sex: F
B) Lic. Issue Date: 05/28/86 D) SS#:

5. A) Name of Medical School:

Albany Medical College of Union University

B) Year Graduated: 82 C) Degree: MD

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 72 | Obstetrics and Gynecology |

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

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

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

**Corrections (type or print)**

Other Name(s):

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

Other Address: About Women By Women
City/Town: 2364 Washington St State:
Zip: Newton Lower Falls, MA 02164 Country: U.S.A.

Home: ( )
Business: (617) 332-0006

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code(s) Hours Per Week in Mass.

If OS, Print Specialty:

Code: Code:

Federal (DEA):
Mass.:

Abbr:

Abbr:

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

**PRINT NAME AND NUMBER:** Last Name: Clark Registration Number: 55906

10. A. Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP).
    Facility Code: 75/✓(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)
    Facility Code: ___/__(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)
    If 999, print name(s): ______

    B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

    Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
    If 999, write Name(s): ______

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ____b) Letter of Credit
    Name of Insurer: Pro mutual.
    *Alternatively, indicate as follows: I 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
    Please explain exemption: ______

12. 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) 20
    B. Care of patients in Massachusetts (see instruction booklet).
    1) Average weekly hours involved in: a) outpatient care 43 hrs/wk b) inpatient care 36 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care ? 0 %

# PART A

**Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.**

## IN THE PAST TWO (2) YEARS:

| | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE:** *Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?* | | |
| 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 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, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? | | |
| 22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? | | |

☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption

See 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 ANSWERED.**

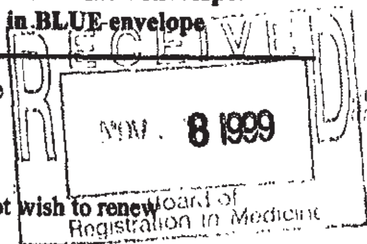
Signature Mary Elizabeth Clark MD Date: 4/9/97

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

# Physician Registration Renewal Application

**Before proceeding, please read the instruction booklet.**
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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




Registration No.: 55906    Renewal Date: 11/15/1999    1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
MOLLY E CLARK

B) Home Address:

Home Phone:
Business Phone:

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

5. A) Name of Medical School:
Albany Medical College of Union University

B) Year Graduated: 1982    C) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | Obstetrics and Gynecology |
| | 0 | |

**Please make corrections (type or print)**

Other Name(s): ______

Mailing Address: ______
City/Town: ______ State: ______
Zip: 02481 Country: ______

Other Address: ______
City/Town: ______ State: ______
Zip: 02481 Country: ______

Home: ( ) ______
Business: ( ) ______

Date of Birth: (M/D/Y): __/__/__ Sex: ☐ M ☐ F
SS#: ___-__-____

Full Name of Medical School:

Year Graduated: ______ Degree: ☐ M.D. ☐ D.O.

Code(s) ______    Hours Per Week in Massachusetts 80

If OS, Print Specialty: ______

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

Code: ______ Code: ______

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

Federal (DEA): ______
Mass: ______

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

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Clark Registration Number: 55906

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

Facility Code: 75/ (AP) ✓ 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

If 999, print name(s): ______

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: MMPIA Alternatively, indicate as follows:

I 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

Please explain exemption: ______

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No

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

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 40 hrs/wk b) inpatient care 40 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

## PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

**Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.**

| Question | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 18. Have you been formally charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association? | | |
| 19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency? | | |
| 20. Have you withdrawn an application for a medical license or been denied a medical license for any reason? | | |
| 21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider? | | |

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

**See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.**

- **Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**
- **Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.**
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: Molly Clark Date: 11/4/99

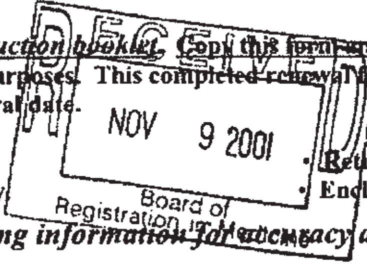
**YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION**

# 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

COMPLETED




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.***

1. Current Status: Active  Registration No.: 55906  Renewal Date: 11/15/2001

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

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

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

**Please make corrections** (type or print)

Other Name(s): ______

3. A) Mailing/Business Address:
MOLLY E CLARK

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

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (781) 263-0033

B) Home Address:

Home Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Home Telephone: (

Home Phone:

Business Phone: (781)237-6250

**PLEASE NOTE: No P.O. Box addresses for home or business addresses.**

4. a) Date of Birth:  b) Sex: F
c) SS#:

5. a) Name of Medical School:
Albany Medical College of Union University
b) Year Graduated: 1982  c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s)  Hours per Week in Mass. 60

OBG 0 Obstetrics and Gynecology
0

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

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

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

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

✓Facility Code: 75/___ (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): ______

PRINT YOUR LAST NAME: Clark LICENSE NUMBER: 55906

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer: Premtual Alternatively, indicate as follows:

I 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

Please explain exemption: ____________________

12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 15

B. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: a) outpatient care 50 hrs/wk b) inpatient care 10 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

## PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

**Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.**

| Question | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 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 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? ☒ Yes ☐ No

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

**See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.**

**Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.**

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

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***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, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: [signature] Date: 11/7/01

**YOU MUST SIGN AND INCLUDE PART B. WITH YOUR RENEWAL APPLICATION**

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

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

**Commonwealth of Massachusetts Board of Registration in Medicine**
**560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org**

# Physician Registration Renewal Application

RECEIVED NOV - 4 2003 Board of Registration in Medicine

**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 *at least 4 weeks* before your renewal date.**

- **Remit $400.00 for renewal fee (non-refundable).**
- **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. All questions must be answered or your renewal will be delayed.***

1. Current Status: Active    Registration No.: 55906    Renewal Date: 11/15/2003

If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one)

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

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

3. A) Mailing/Business Address:
MOLLY E CLARK

B) Home Address:

Home Phone:

Business Phone: (781) 263-0033

**Please make corrections (print)**

☐ Other Name(s)  ☐ Name Change (enter name below)

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

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

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

**PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.**

4. a) Date of Birth:    b) Sex: F
c) SS#:

5. a) Name of Medical School:
Albany Medical College of Union University
b) Year Graduated: 1982  c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s)  Hours per Week in Mass.
OBG  (80) 70  Obstetrics and Gynecology

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

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

10. List all current health care facilities at which you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to each facility, write the approximate percentage of patient care hours that you provide in each facility). ___ No affiliations.

✓Facility Code: 75/__ (AP) 99 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
✓Facility Code: 921/__ (AP) 1 % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): ______

PRINT YOUR LAST NAME: Clark LICENSE NUMBER: 55906

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): Crico Policy dates: From: 1/1/03 To: 1/1/04

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption:

12. What is your principal work setting? (See Table 4) 222 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. *Care of patients in Massachusetts (see instruction booklet).*

1) Average weekly hours involved in: A) inpatient care 34 hrs/wk B) outpatient care 36 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

## PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

**Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.**

| | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE (New or Pending):** Has any medical malpractice claim been made against you that has not yet been *finally* settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS (Resolved):** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense? | | |
| 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 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? ☑ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

**CME EXEMPTION:** Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

**See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.**

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

**I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.**

Signature: Molly Elizabeth Clark MD Date: 10/31/03

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

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

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

# Massachusetts Physician Renewal Application

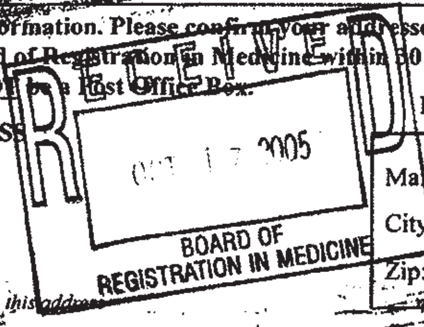
**Physician Name:** Molly E Clark **License No.:** 55906

**PART A**

**1). Current Status:** Active **Renewal Due Date:** 10/18/2005 **Birth Date:**

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

☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew




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

**Please make corrections (print)**

**2a) MAILING ADDRESS**

☐ *Check here to change this address*

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

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

Home Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Home Telephone: (___) ______

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**

About Women By Women, PC
195 Worcester St
Wellesley, MA 02481

Phone: (781)263-0033

☐ *Check here to change this address*

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (___) ______

*Business address cannot be a Post Office Box*

**3) E-mail Address:**

**4) Fax Number:** ______

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **Additional specialties:** |
|---|---|---|
| Obstetrics and Gynecology | ☐ | |
| | ☐ | |
| | ☐ | |

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

**List Certifying Board(s) below:** | **Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**

| Board Name | ABMS or AOA | Certificate/Subspecialty | Correct? | Delete? |
|---|---|---|---|---|
| Obstetrics & Gynecology | ABMS | Obstetrics and Gynecology | ☑ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |



10/18/05 15 10

# Massachusetts Physician Renewal Application

**Physician Name:** Molly E Clark **License No.:** 55906

10/18/05 S1 11

| *(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: Private Office Change to: ____________

Please enter the *approximate* number of work hours at your principal work setting: 36

**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** ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

| **Health Care Facility** *(See Renewal Instructions, page 4.)* | Delete? | **Staff Category** Current | **Staff Category** Change | ***Approximate*** **# Hours per Week** |
|---|---|---|---|---|
| Brigham & Women's Hospital | ☐ | Active | | 0-4 |
| Newton-Wellesley Hospital | ☐ | Admitting | | 24 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

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

Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: ____ hrs/wk

b) outpatient care 36 hrs/wk Change to: 40 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: CRICO

Policy dates: From 1/1/05 To 12/31/05
*(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* ____________

# Massachusetts Physician Renewal Application

**Physician Name:** Molly E Clark **License No.:** 55906

10/18/05 S1 12

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

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

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

| Question | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<br>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?<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Are there any criminal charges pending against you today?<br>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? ☑ Yes ☐ No

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

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

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

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

# Massachusetts Physician Renewal Application

**Physician Name:** **Molly E Clark** **License No.:** **55906**

10/18/05 S1 14

## PHYSICIAN PROFILE

☑ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.

☐ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.

☐ My status is Inactive and I do not have a Physician Profile. (*See Renewal Instructions, page* 10.)

## CERTIFICATIONS

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.

6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.

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

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

Signature: Molly Clark Date: 10/12/05

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

# Massachusetts Physician Renewal Application

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

## PART A

**1) Current Status:** Active **Renewal Due Date:** 10/18/2007 **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**

RECEIVED
OCT 23 2007
Board of Registration in Medicine

☐ *Check here to change this address*

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

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

Home Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Home Telephone: (___)______

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**
About Women By Women, PC
195 Worcester St
Wellesley, MA 02481

Phone: (781)263-0033

☐ *Check here to change this address*

Business Address: ______
City/Town: ______ State: ______
Zip: ______ Country: ______
Business Telephone: (___)______

*Business address cannot be a Post Office Box*

**3) E-mail Address:** ______

**4) Fax Number:** ______

**Correct your E-mail and Fax Number below:**

______

4) FAX (781) 263-0098

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **List Additional Specialties:** |
|---|---|---|
| Obstetrics and Gynecology | ☐ | |
| | ☐ | |
| | ☐ | |

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

**List Certifying Board(s) below:** | **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 | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

*(See Renewal Instructions, page 4.)*

**7) Drug License Numbers** **Corrections:**

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

*Please make corrections as necessary*

**8) Other states where you are now licensed to practice**

___ ___ ___ ___ ___ ___ ___

**9) States where you were previously licensed**

___ ___ ___ ___ ___ ___ ___

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

| List the names of all work sites in Massachusetts *(See above and description on page 4.)* | Location (City or Town) | State | Delete? |
|---|---|---|---|
| Brigham & Women's Hospital | Boston | MA | ☐ |
| Newton-Wellesley Hospital | Newton | MA | ☐ |
| About Women By Women | Wellesley | MA | ☐ |
| Women's Health Services | Chestnut, Hill | MA | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: 24 hrs/wk
b) outpatient care 40 hrs/wk Change to: 50 hrs/wk

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

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

☒ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: ____________

Policy dates: From 1/1/2007 To 12/31/2007

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:** Molly E Clark, M.D. **License No.:** 55906

**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.

| Question | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<br>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).<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Have any criminal offenses/charges against you been resolved during this time period?<br>c) Are there any criminal charges pending against you today?<br>d) Are any Applications for Issuance of Process pending against you? | | |
| **18) INVESTIGATIONS AND DISCIPLINARY ACTIONS**<br>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?<br>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?<br>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?<br>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? | | |
| **19)** Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| **20)** Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? | | |
| **21)** Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? | | |

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name: Molly E Clark, M.D.** **License No.: 55906**

## PART C

**Check One:** **PHYSICIAN PROFILE**

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

**CERTIFICATIONS**

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

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

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

4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.

5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.

6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.

7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.

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

9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.

10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c.119A.

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

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

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

Signature: Molly Clark MD Date: 10 / 21 / 07

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

# Massachusetts Physician Renewal Application

**Physician Name: Molly E Clark, M.D.** **License No.: 55906**

**NATIONAL PROVIDER IDENTIFIER (NPI)**

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

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the 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 Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

- ☑ My current NPI is: 1 0 4 3 2 2 3 3 2 4
- ☐ 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 (Specialty) Code | Taxonomy Description (Print) |
|---|---|---|
| Primary Provider Taxonomy: | 2 0 7 V 0 0 0 0 0 X | Obstetrics + Gynecology |
| 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): New York Country of Birth (if outside the US): ______________

Gender: ☐ Male ☒ Female

**Penalties for Falsifying Information on the National Provider Identifier Application**

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

**Authorization for NPI Dissemination**

**Check one box: ☑ I authorize ☐ I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

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

Signature: Molly Clark Date: 10 / 21 / 07

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

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

**Current Status:** Active **License Expiration Date:** 11/15/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**

About Women By Women, PC
195 Worcester St
Wellesley
Massachusetts - 02481
United States of America
(781) 263-0033

3) **Email Address:**

4) **Fax Number:** (781) 263-0098

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 |
|---|---|---|---|
| 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 | Boston |
| Newton-Wellesley Hospital | Newton |

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



Women's Health Services,PC. Chestnut Hill

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Controlled Risk Insurance Company of Verm | 01/01/2009 | 12/31/2009 | Occurrence Policy |

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

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

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

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

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

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

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

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

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

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

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

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

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

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

**Current Status:** Active **License Expiration Date:** 11/15/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America

**Home Address:**

**Business Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America
(781) 263-0033

3) **Email Address:**

4) **Fax Number:** (781) 263-9125

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 |
|---|---|---|---|
| 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 |
|---|---|
| Newton-Wellesley Hospital | Newton |

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

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2011 | 12/31/2011 | Occurrence Policy |

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

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

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

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

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

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

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

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

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:** Molly E Clark, M.D. **License No.:** 55906

---

**Current Status:** Active **License Expiration Date:** 11/15/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America

**Home Address:**

**Business Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America
(781) 263-0033

3) **Email Address:**

4) **Fax Number:** (781) 263-9125

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 |
|---|---|---|---|
| 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 |
|---|---|
| Newton-Wellesley Hospital | Newton |

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

**Physician Name:** Molly E Clark, M.D. **License No.:** 55906

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2013 | 12/31/2013 | Occurrence Policy |

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

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

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

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

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b) Have any criminal offenses/charges against you been resolved during this time period?
c) Are there any criminal charges pending against you today?
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**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:** Molly E Clark, M.D. **License No.:** 55906

**Current Status:** Active **License Expiration Date:** 11/15/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America

**Home Address:**

**Business Address:**
30 Washington Street
Wellesley
Massachusetts - 02481
United States of America
(781) 263-0033

3) **Email Address:**

4) **Fax Number:** (781) 263-9125

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 |
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| ABMS | Obstetrics & Gynecology | Obstetrics and Gynecology | |

7) **Drug License Numbers**

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

9) **States where you were previously licensed**
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 |
|---|---|
| Newton-Wellesley Hospital | Newton |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 24 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2015 | 12/31/2015 | Occurrence Policy |

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

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

**15) Claims Closed**
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**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?**

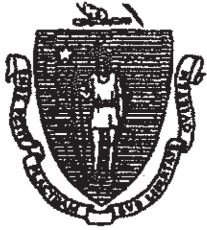
22) **Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.** Yes

**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?**

**25) Electronic Health Records Proficiency**
I have demonstrated proficiency in the use of EHR by employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital that has a CMS Meaningful Use program.

**26) Requirement to Complete Training in Recognizing and Reporting Child Abuse**
Have you completed training to recognize and report suspected child abuse or neglect?



Commonwealth of Massachusetts
# Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
An Agency within the Office of Consumer Affairs and Business Regulation

ALEXANDER F. FLEMING
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PENELOPE WELLS
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CHAIRMAN
CARL M. SAPERS
VICE-CHAIRMAN
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BOARD MEMBER

05/05/08 15 89

November 13, 1997

Molly Clark, M.D.

REDACTED COPY

Re: Complaint No: 97-252

Dear Dr. Clark:

After your appearance at the Complaint Committee of the Board on Wednesday, November 12, 1997, the Committee discussed the above mentioned complaint

The Committee also determined that no further action was warranted and the complaint was dismissed. Thank you for your cooperation in the investigation of this matter. The Committee appreciates the time and effort which you expended in preparing your response. If you have any questions, please call the Consumer Protection Unit at (617) 727-1788, or write to it at the above address.

Very truly yours,

Mary Anna Sullivan, M.D.
Clinical Care Committee Chairperson

MAS\kms
cc: James H. Anderson, Esq.

03/03/08 S1

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Molly Clark, M.D.

September 28, 1997

Mr. Stephen Giacobbe
Special Investigator
Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Re: Complaint No. 97 - 252

Dear Mr. Giacobbe,

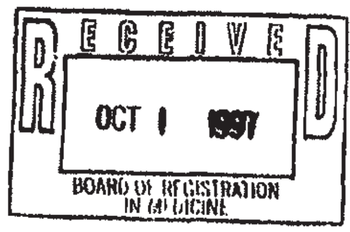
This letter is in response to your letter of September 3, 1997 requesting a detailed written response to issues raised in complaint no. 97-252.

As you know, my husband, , has a long history of chronic tension headaches. has consented to the release of this medical information. I understand that copies of his medical records have been sent to the Board. He was evaluated in the late 1970's at the Faulkner Hospital Headache Clinic. This evaluation was complete and included a CAT Scan and neurologic exam which were normal. He was given a prescription for Fioricet which could be refilled indefinitely.

In the 1990's my husband requested that I write him occasional prescriptions for Fioricet. I was unfamiliar with the Massachusetts guidelines for prescribing this medication. I did not document his symptoms or the dates prescriptions were written or the quantity of pills prescribed.

Approximately five years ago my husband was promoted to a high level administrative position in public education. This is a very stressful position which requires my husband to work very long hours, often in a confrontational setting. In this setting his tension headaches worsened. Over time, his tolerance to Fioricet increased and he was taking one or two pills every four to six hours for his headaches. During this time he often had active prescriptions in more than one pharmacy. Because I was not keeping records of these prescriptions, I lost track of the quantity of Fioricet that was taking.

In April, 1997 I was notified by a Needham pharmacist of my husband's excessive Fioricet usage. I insisted that he immediately see his internist, at Newton Wellesley Hospital. was seen the following day and was carefully evaluated by n and was found to have severe hypertension. He was immediately started on a Beta-blocker for his hypertension and headaches. He has had two subsequent follow-up visits. He is currently taking antihypertensive medication and two Fioricet tablets per day. His diastolic BP is now between 100 and 110. At his last visit in mid-September his anti-hypertensive dosage was further increased.



I deeply regret my ignorance of the law reflected in my unfamiliarity with the prescribing guidelines for this drug and failure to document the prescriptions I wrote for my husband. Most of all, I regret that my care of my husband prevented him from receiving thorough medical attention from an internist. Had I done so, his hypertension might have been diagnosed several years earlier, avoiding the risks and potential future consequences of severe hypertension.

Please do not hesitate to contact me if you need any further information. Please inform me of the date that my case will be presented to The Complaint Committee. I would like to attend the meeting to answer any questions regarding the investigation.

Sincerely,

Molly Clark, M.D.

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

09/03/08 15 72

April 2, 2008

Molly E. Clark, M.D.
C/o James S. Hamrock, Esq.
Hamrock & Tocci
101 Main Street, 18th Floor
Cambridge, MA 02142

REDACTED COPY

Re: Docket Number: 07-627

Dear Dr. Clark:

The Complaint Committee of the Board of Registration in Medicine met today and considered the above referenced complaint.

The Committee has determined that no further action is warranted and the complaint has been closed. Despite the decision to close the complaint, the Board reserves the right to reopen the complaint should you commit any violations of Board statutes or regulations in the future.

Sincerely,

Randy Ellen Wertheimer, MD

Randy Ellen Wertheimer, M.D.
Complaint Committee Member

RW/jab

Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
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Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

April 3, 2008

Re: Molly E. Clark, M.D.
Docket Number: 07-627

Dear

The Complaint Committee of the Board of Registration in Medicine met and carefully considered the information you furnished regarding Dr. Clark. A copy of your complaint was sent to Dr. Clark, who was required to respond in writing to the Board regarding the issues that you raised.

After a thorough review of the evidence, the Committee determined that your complaint and Dr. Clark's response should be placed in her permanent record . While the Committee declined to recommend the initiation of formal disciplinary action in this matter, it is appreciative of your actions in bringing this matter to its attention.

Should you have any questions I can be reached at the number or address above.

Very truly yours,

Jennifer A. Brown

Jennifer A. Brown
Consumer Protection Manager

JAB/jec
Enclosure

Commonwealth of Massachusetts
# Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

Enforcement Division Fax: (617) 451-9568
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Licensing Division Fax: (617) 426-9358

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

09/08/08 S1
04/08/08 S7
74
22

October 5, 2007

**VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED**

Molly E. Clark, M.D.

7006 0810 0000 7657 6760

Re:

Docket Number: 07-627

Dear Dr. Clark:

The Board of Registration in Medicine has received a complaint regarding your conduct in the practice of medicine, a copy of which is enclosed.

Please provide a written response, signed by you, to the issues raised in the enclosed material. As part of your response, you may include any materials you feel are relevant in connection with the investigation of this matter. Pursuant to Board regulations and statutes, the person filing the enclosed complaint may have access to your response.

You are welcome to have an attorney represent you in this matter. Please note that if an attorney does represent you, either you or your attorney may write your response, but you must sign or co-sign it as the licensee.

Your response must be sent to me, at the address above, within thirty days. This time frame commences on the date listed above. After your response is received, the case will be reviewed and a determination will be made about how to proceed. You will be notified of this decision.

Thank you for your attention to this request.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/cjm
Enclosure

# Commonwealth of Massachusetts
# Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8463
Licensing Division Fax: (617) 426-9358

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR

09/03/08 S1
04-08-08 S1
75
16

October 5, 2007

Re: Molly E. Clark, M.D.
Docket Number: 07-627

Dear

Your complaint regarding the physician named above has been received. The physician involved has been asked to respond in writing to your complaint. Any future correspondence regarding your complaint should include the name of the physician and the docket number as it appears in this letter.

If you wish to bring additional information bearing on your complaint to the attention of the Board, please furnish it in writing to me at the address above.

Very truly yours,

Jennifer A. Brown

Jennifer Brown
Consumer Protection Manager

JAB/cjm

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR



Commonwealth of Massachusetts

# Board of Registration in Medicine

560 Harrison Avenue, G-4
Boston, Massachusetts 02118
(617) 654-9800

Enforcement Division Fax: (617) 451-9568
Legal Division Fax: (617) 357-8453
Licensing Division Fax: (617) 426-9358



MARTIN CRANE, MD
BOARD CHAIR

NANCY ACHIN AUDESSE
EXECUTIVE DIRECTOR



09/09/08 S1 76
04/08/08 S7 17


November 30, 2007

Re: Molly E. Clark, M.D.
Docket Number: 07-627

Dear

Enclosed please find a copy of Dr. Clark's response. You will be notified when there is a disposition in this matter.

In the meantime if you have any questions, I can be reached at (617) 654-9800 ext. 4033.

Very truly yours,

Jennifer A. Brown

Jennifer A. Brown
Consumer Protection Manager

JAB/jec
Enclosure

About Women By Women, P.C.
Obstetrics • Gynecology • Infertility

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NOV 19 2007
Board of Registration in Medicine

Sharon S. Margulies, MD, FACOG
Sibel N. Bessim, MD, FACOG
Molly E. Clark, MD, FACOG
Diane E. Tarr, MD, FACOG
Georgia S. Vasilakis, MD, FACOG
Lori J. Stack, MD, FACOG

09/03/08 16:26 FAX

November 16, 2007

Ms. Jennifer Brown
Consumer Protection Manager
Commonwealth of Massachusetts
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, MA 02118

Re:
BRM Docket Number: 07-627

Dear Ms. Brown:

This letter is in response to the Complaint filed by regarding obstetrical care I provided to her in 2004.

was a patient of About Women By Women during her 2004 twin pregnancy. I was her primary obstetrician in the practice. The last visit she had with me was October 20, 2004, at which time she was 21 weeks pregnant. She was being followed with regular ultrasounds due to her twin pregnancy. Her most recent ultrasound had been September 23, 2004. It was performed by our Senior Sonographer, who has over 30 years experience as an ultrasound technician. It showed reassuring growth of both twins and a normal, closed cervix of normal length.

had her next ultrasound on November 2, 2004, at 23 weeks' gestation. It was also performed by The ultrasound showed excellent growth of both twins. The cervix length was measured at 2.8cm, and was documented on the sonographer's worksheet. A cervical length of 2.5 cm or longer is considered normal. Although this visit was only for the performance of the ultrasound, appropriately asked our nurse practitioner, , to check cervix, since its length was somewhat less than at the prior ultrasound. Ms. is an experienced nurse and nurse practitioner with over 25 years' experience as a Labor and Delivery Nurse and as a Certified Nurse Practitioner. As an experienced RNP and a former L&D Nurse, has a great deal of experience doing vaginal exams. As she is also the mother of twins, she is the primary nurse practitioner for most of our patients with twins.

195 Worcester Street, Wellesley, MA 02481 • 111 Norfolk Street, Walpole, MA 02081 • 808 Main Street, Waltham, MA 02451
Tel: (781) 263-0033 • Fax: (781) 263-0098

exam confirmed that cervix was of normal length and closed. This is documented on the sonographer's worksheet.

Ultrasound exams performed in our office are read at Newton-Wellesley Hospital the following day. The sonographer's report accompanies the ultrasound tape to the Hospital. The radiologist calls our practice the following business day if any discrepancies are noted between the sonographer's worksheet and the radiologist's reading of the tape. Our office was not called, which indicates that the radiologist did not have any significant concerns with our sonographer's findings.

The radiologist's typed report was received at About Women by Women on November 9, and I reviewed it that day. It stated that "the cervix appeared slightly foreshortened and there was a suggestion of funneling." The radiologist made note of the fact that the patient's cervix was checked after the ultrasound had been performed. The cervix was found to be normal and closed. I reviewed the sonographer's report, which documents both the normal cervix length of 2.8 cm and the Nurse Practitioner's exam findings of a normal and closed cervix, and the radiologist's report. I then signed, as is my practice, the ultrasound report with my initials and I listed the date November 9, 2004. I also wrote that the patient was notified in person that the SVE (sterile vaginal exam) had shown that her cervix was closed on November 2, 2004 (the day the ultrasound was performed), because l always notifies her patients of this information when she performs a vaginal exam at any stage of pregnancy.

Although I was not personally involved in care on November 2, 2004, nor was I advised on that date of the ultrasound findings, I must respectfully disagree with her suggestion that my involvement would have changed the unfortunate outcome of her pregnancy. cervical length measure done November 2 by an experienced sonographer was normal at 2.8 cm. Her vaginal exam by an experienced obstetrical nurse practitioner confirmed that the cervical length was normal and that the cervix was closed. After these unfortunate events, I reviewed the actual ultrasound tape. To my view, the cervix was closed, and the length was normal (greater than 2.5 cm). It is extremely unlikely that any exam on November 2 by me, or any other obstetrician, or any review that day by me, or any other obstetrician, of the ultrasound would have resulted in any different outcome.

was next seen in our office for a non-scheduled visit on November 9, 2004 at 24 ½ weeks. She had called to report vaginal spotting, which had occurred at work. She thereafter noted cramping. was directed to come immediately to the office. She was examined by my colleague , who found her to be fully dilated. was transferred to Newton-Wellesley Hospital and delivered her vertex-breech twins by cesarean section. The surgery was performed by my two colleagues, and . Tragically, one twin died in the NICU at Newton Wellesley, and the other twin was transferred to Children's Hospital. Several hours post-partum, Children's Hospital called to advise that the baby was not doing well and was transferred to Brigham and Women's Hospital to be closer to her baby.

I was not notified by any member of my office or any of my fellow physicians that delivered her twins on November 9, or that one had died and that the other was transferred to



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Brigham and Women's. Given the usual 24 hour coverage shift each of us has at Newton-Wellesley every fifth day, in the normal course of events I likely would have seen and examined during her hospital stay following the cesarean section. However, since she was transferred to Brigham and Women's within a day of the delivery, I did not have the opportunity to see her at Newton-Wellesley. If I had been notified of the events, I would have certainly visited if she were still at Newton-Wellesley, and I would have called her if she were at Brigham and Women's Hospital.

An undated note in the office medical record indicates that I was notified that underwent an emergency cesarean section. My notes indicate that there was an inquiry regarding placental pathology. It is clear to me that it was not until this inquiry, about a week after the delivery, that I learned of her emergency delivery. My notes indicate that I looked up the pathology report in the Newton-Wellesley Hospital computer, and I wrote that the pathology report was pending. My notes indicate that I attempted to call at what I understood to be the home phone number of on November 16 at 6:40 pm, and on November 18 at 2:20 pm. On both occasions, my notes indicate that I left a message on the answering machine. I have no direct memory of these calls. I suspect I obtained the home phone number from the demographic section of the Hospital computer, after looking up her placental pathology report on the computer.

On November 19, 2004 I saw for her two-week post-partum exam. Until that time, I was unaware that had already lost one of her twins. I felt very embarrassed to be told by that one of her twins had died, in response to my inquiry as to how they were doing. I tried to apologize and to explain to her that I had been unaware of her delivery until a week after it happened. given the circumstances of having lost one baby and the other being in the NICU, was understandably upset.

The physical exam itself, including incision check, was unremarkable. At the visit, informed me that her employer, , was limiting her maternity leave and she wanted to return to work on November 22, in order to preserve maternity leave time when the baby in the NICU would be able, hopefully, to go home. At her request, I wrote a hand-written note that day to fic requesting this arrangement. Following the visit, I dictated a letter to the Human Resources Department of the company requesting a delay in use of maternity leave. Also at this visit, I discussed with her relatively painless cervical dilation of November 9. We discussed issues about an incompetent cervix and the possible placement of a cerclage for future pregnancies.

I am very sorry that I did not learn until a week later about emergency delivery. As indicated above, in our normal coverage schedule at the Hospital I would most likely see any post-operative cesarean-section patient of our practice, and through our routine discussions every day at the office I would expect to hear of any emergency c-section delivery of premature twins by any physician in our practice. I deeply regret that this communication did not occur. Since that time, and to avoid a repeat of this situation, our practice's covering physician, at the end of her shift at Newton-Wellesley Hospital, now emails or leaves a telephone message for the primary obstetrician of any important development in a patient's care. I am also very sorry that I did not

learn of the death of one of the twins until post-partum visit. I pride myself on providing informed and empathetic care to all of my patients over the past 25 years. Perhaps viewed my embarrassment as defensiveness, but I sincerely regret if she did not see the sympathy I felt for her and her husband. While the extremely premature birth of the twins was not something that the November 2 ultrasound predicted, I continue to feel sympathy for and her husband over the loss of the twins.

I have enclosed the pertinent sections of my office's records for , including the prenatal care charting, the sonographer's notes of the November 2 ultrasound, the radiologist's report, the Hospital operative note regarding the delivery, the post-partum office visit note, and the two letters I wrote on behalf to her employer. Please let me know if the Board needs any additional information or documents.

Sincerely

Molly Clark, M.D.



04/09/08 13:35
09/08/08 15:08

RECEIVED
-3 2007
Board of Registration
in Medicine

08/03/08 S1 04:08:08 S1 18 E

**COMPLAINT FORM**

Please type or print clearly, and provide all of the information requested.

☒ Mrs. ☐ Ms. ☐ Mr. Your First Name ______ Your Last Name ______ Patient Name (if different) ______

Street Address ______ Mailing Address (if different) ______

City ______ State MA Zip Code ______

Business/Daytime Phone ______ Home Phone ______

Complaint against M.D. X, D.O. ____, Acupuncturist ____.

(For complaints against Chiropractors, Psychologists, Optometrists or Podiatrists, please contact the Division of Professional Licensure at (617) 727-7406, or 239 Causeway Street, Boston, MA 02114. For complaints against Dentists, Nurses or Physician Assistants, please contact the Division of Health Professions Licensure at (800) 414-0168 or 239 Causeway Street, Boston, MA 02114. )

This complaint cannot be processed without the full name of the physician or acupuncturist. Please verify spelling.

Full Name (First & Last) of Physician or Acupuncturist (one name per form) Photocopies are acceptable.

Molly E. Clark, MD

Address

195 Worcester Street

City Wellesley State MA Zip Code 02481

Business Phone (781) 263-0033

Name and Location of Health Care Facility (if known)

About Women By Women (AWBW)

Nature of Complaint

| | | | |
|---|---|---|---|
| ☒ | Substandard Medical Care | ☐ | Drug Dealing |
| ☐ | Professional Misconduct | ☐ | Criminal Conviction |
| ☐ | Sexual Misconduct | ☐ | Patient Neglect/Abandonment |
| ☒ | Rude or Discourteous Behavior | ☐ | Unlawful Discrimination |
| ☐ | Impaired by Alcohol or Drugs | ☐ | Billing for Services Not Rendered |
| ☐ | Impaired by Mental or Emotional Illness | ☐ | Failure to Supervise Staff |
| ☐ | Failure to Provide Medical Records | ☐ | False Advertising |
| ☐ | Overcharge for Medical Records | ☐ | Fraud |

☐ OTHER ______

Failure to complete and sign this release may prevent investigation of your complaint.

**Release of Medical Records and Information**

Patient Name: ____ ______________ Date of Birth: _

Address: _ ______________________

I HEREBY AUTHORIZE ANY AND ALL HEALTHCARE PROVIDERS OR INSTITUTIONS TO RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO, AND TO DISCUSS MY MEDICAL CARE WITH, THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE.

**Signature of Patient:** ___ ___________ Date: October 01, 2007
(Or Legal Representative)

I FURTHER AUTHORIZE MY MENTAL HEALTH PROVIDER(S) TO DISCUSS EVALUATIONS, DIAGNOSES OR TREATMENT AND/OR RELEASE ANY AND ALL OF MY MEDICAL RECORDS TO THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE. THIS AUTHORIZATION REPRESENTS A WAIVER OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE, AS DESCRIBED IN G.L. c. 233,§ 20B.

**Signature of Patient:** ___ ___________ Date: October 01, 2007
(Or Legal Representative)

Please list the names and addresses of all healthcare providers and institutions that provided treatment which may relate to this complaint.

Molly E. Clark, MD (obstetrician)
Marcia (Ultrasonographer - last name unknown)
Diane (Nurse - last name unknown)

If you are not the patient, what is your relationship to the patient?
☐ Spouse, ☐ Parent, ☐ Child, ☐ Other Relative________, ☐ Friend, ☐ Attorney, ☐ Other________

Has this physician provided treatment in the past? (Do not count the treatment in this complaint.)
☒ Yes, ☐ No — for regular gynecological care

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☒ No — I have a primary care physician for that

How long have you (or patient) been under this physician's care?
☐ 1 to 30 days, ☒ 1 to 12 months, ☐ 1 to 2 years, ☐ 2 to 4 years, ☐ 4 to 8 years, ☐ 8 years or more

What form of payment was made? Check as many as apply.
☐ Commercial Insurance, ☒ Health Maintenance Organization, ☐ Medicaid, ☐ Medicare, ☐ Champus
☐ Workers' Compensation, ☐ Self, ☐ Other________________

Are you (or patient) expected to pay a portion of this bill out of pocket?
☐ Yes, ☒ No

Has the physician adjusted the bill in any way, for example, was the fee or copayment reduced or waived?
☐ Yes, ☒ No

Is the fee or copayment in dispute?
☐ Yes, ☒ No

Has the physician been contacted about this complaint?
☐ Yes, ☒ No

Dates of Treatment: Late Fall 2003 through November 2004

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04/08/08 S1 4

Describe your complaint here or attach. If you need more space, continue on reverse or on another sheet of paper.

In May 2004, following a year of infertility, I became pregnant with girl/boy twins via IVF. On November 2nd, 2004, my husband and I went into About Women By Women (AWBW) for a routine ultrasound. There, at 23.5 weeks gestation, the ultrasonographer ( ) observed our son to be extremely low in my pelvis and asked for a nurse ( ) to come in and examine me. The nurse did a digital exam and determined that my cervix was closed. She said I did not need to see my obstetrician, Dr. Molly Clark. My husband and I went home assured that nothing was wrong.

Exactly one week later, on November 9th, 2004 and at 24.5 weeks gestation, I unexpectedly went into labor and had an emergency C-section. Our son and daughter each weighed less than two pounds. Our son died early the next morning from a Group B Strep infection; our daughter died 18 days later in surgery following health complications.

At the time of the twins' birth and during my entire stay in the hospital (November 9th – 12th), _not once_ did Dr. Clark call or visit me in the hospital. In fact, my husband and I did not have any correspondence with Dr. Clark until we had to physically return to AWBW on November 19th, 2004 for a follow-up wound care appointment. By then, our son had died but our daughter was still alive in the NICU at Children's Hospital. Pathetically – (and despite the fact that two of her own colleagues from AWBW had performed my C-section) – Dr. Clark was not aware of the children's' status and, as we walked into her office, blankly asked us how the twins were doing...

At the end of the appointment, my husband calmly conveyed to Dr. Clark our disappointment in her regarding her neglect during my hospital stay and the days leading up to this follow-up appointment, as well as her obvious lack of knowledge in my condition and/or that of our children at that time. We expected to hear an apology from her. Instead, Dr. Clark's demeanor turned defensive and she coolly denied that she did anything wrong, adding that she had placed two phone calls to our home during the period in question. That was all she said and she would not elaborate any further. We walked away from the practice greatly saddened and stunned. We immediately decided to end our ties with Dr. Clark and AWBW. A few weeks later, I put in a request for copies of my entire medical record.

Upon receipt of my medical record, I was able to review the November 2nd, 2004 ultrasound report for the very first time. Reading this made my heart break a thousand times over, for twice in this report is the statement ***"...cervix is slightly foreshortened and there is a suggestion of funneling"***. In addition, in the upper right hand corner of the report, the time/date stamp indicates that the report was not reviewed until November 9th, 2004 – (incidentally, the same day that the twins were born) – and, in her own handwriting, Dr. Clark noted that my cervix had been checked and was closed.

I wish the Medical Board to investigate two issues:

1) How could my OB make such a statement when she, herself, never actually checked my cervix?

2) Why did it take a full week for this report to be reviewed and signed off? Again, the fact that the review occurred the same day as the twins' birth is suspicious. Furthermore, had Dr. Clark become more involved at that November 2nd, 2004 appointment, perhaps my twins' birth could have been prevented and/or delayed by putting me on bedrest or administering tocolytics.

In addition to substandard medical care, I would also like to address Dr. Clark's lack of contact with me at the time of the twins' birth (November 9th, 2004). Dr. Clark claimed to have made attempts to reach my husband and me at home and, from our review of my records, there is documentation that she tried to call. However, these two calls were placed to an old phone number per information in AWBW's computer system that had not been updated. Had Dr. Clark properly reviewed my chart, she would have noted my correct phone number on my prenatal forms that were recorded on July 23rd, 2004 by a nurse at AWBW. Moreover, the calls were not placed until November 16th and 18th, long after I had been released from the hospital. As her patient, I would have expected – and hoped – that my obstetrician would be invested in my well-being at the time of my hospitalization when I needed her most. Evidently, this was not the case.

Attach copies of related documents to this form.
The information in this complaint is true, correct and complete to the best of my knowledge.

Your signature: ________________ Date: October 01, 2007

Mail this form to: Consumer Protection Manager
Board of Registration in Medicine
560 Harrison Avenue, G-4
Boston, MA 02118