Commonwealth of Massachusetts Board of Registration in Medicine

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

Physician Registration Renewal Application

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

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

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

REDACTED COPY

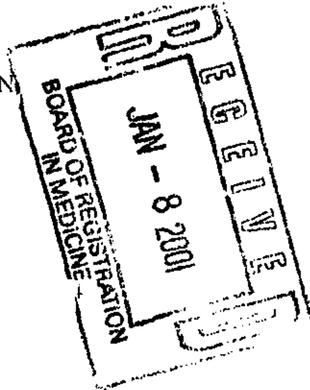
1. Current Status: Active Registration No. 57880 Renewal Date: 02/06/2001

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:

3. A) Mailing/Business Address:
YVONNE GOMEZ-CARRION



B) Home Address:

Home Phone:

Business Phone:
(617) 524-9270

Please make corrections (type or print)

Other Name(s): ____

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

Business Address: 2 Harris Ave.
City/Town: Jamaica Plain State: MA
Zip: 02130 Country: USA
Business Telephone: (617) 524-9270

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

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:
Columbia Univ. College of Physicians & Surgeons
b) Year Graduated: 1983 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass. 40
OBG 0 Obstetrics and Gynecology
0

7. Current American Board of Medical Specialties Certification (See Table 2)
OGCode: 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: 4 4 1/ ✓ (AP) 20 % Facility Code: ___/__ (AP) ___% Facility Code: ___/__ (AP) ___%
Facility Code: __151/__ (AP) 80 % Facility Code: ___/__ (AP) ___% Facility Code: ___/__ (AP) ___%
If 999, print name(s): ____

PRINT YOUR LAST NAME: Gomez-Carrion LICENSE NUMBER: 57890

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Name of Insurer: CRICO 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 ☐ 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) 1 5
b) Care of patients in Massachusetts (see instruction booklet).
i) Average weekly hours involved in: A) inpatient care 30 hrs/wk B) outpatient care 30 hrs/wk
ii) What is the approximate percentage of your patient care hours in primary care? 75 %

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 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 and have complied with all laws of the Commonwealth related to reporting of employees and contractors.***
- ***Pursuant to G.L c. 62C, § 49A, to the best of my knowledge and belief, I am in compliance with G.L. 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: 12/30/00

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
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
57880	ACTIVE	$250.00	02/06/95	$25.00

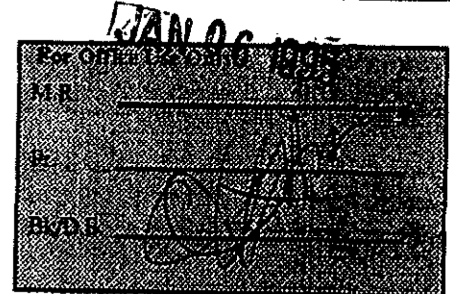
Mailing Address:
YVONNE GOMEZ-CARRION, M.D.

Correction of Mailing Address

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:
   435 WARREN STREET
   ROXBURY COMP COMM HEALTH
   ROXBURY, MA 02119
3. Date of Birth: Sex: F
   Lic. Issue Date: 06/24/87 SS#: - -

   Home Phone
   Business Phone (617)442-7400
4. Name of Medical School:
   Columbia Univ. College of Physicians & Surgeons
   Year Graduated: 83 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr): NY
   b) States where you previously were licensed to practice (Abbr):
6. Specialty Code(s) (See Table 1):
   Code Hours per Week in Mass.
   OBG 60 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
9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

Corrections of Pre-Printed Information

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

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

Home: ( ) ______ Business: ( ) ______

Full Name of Medical School: ______

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

NY

Code Hours per Week in Mass.

If OS, print specialty: ______

Code: ______ Code: ______

Federal (DEA): ______
Mass: ______

- **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: Gomez-Carrion Registration Number: 57880

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: 69 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

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

If 999, print name(s): ______

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

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

If 999, write name(s): ______

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

List Insurer: CRICO (Controlled Risk Insurance Co, Ltd)

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) 25

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? 36 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 24 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 60 %

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: [signature] MD Date: 1/4/95

12244.0000

I. PHYSICIAN INFORMATION

YVONNE		GOMEZ-CARRION	
First Name	*Middle Initial*	*Last Name*	*Suffix*

Make changes to name here

Mass License # 57880
License Status Active

First Issue Date 06/24/87

Hospital Affiliation

Beth Israel Hospital

435 Warren St.
Roxbury Comp Comm. Health
Roxbury, MA 02119-1833
U.S.A.
(617) 442-7400 X239

Make address corrections here:

X243

Make any corrections to above here:

Insurance Plan Affiliation:

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No
Accept Medicaid? ☑ Yes ☐ No

II. EDUCATION & TRAINING

Columbia Univ. College of Physicians & Surgeons	MD	83
Medical School	*Degree*	*Date*

Make corrections here

Columbia University Medical Center	7/83	6/87
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

Details of claims paid for Dr. GOMEZ-CARRION

No. of Years in Practice: # 9

Date	Amount Paid	Basis for Complaint
	0.0000	

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
'95 Roxbury Comprehensive Community Health Center's Employee of the Year'	

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

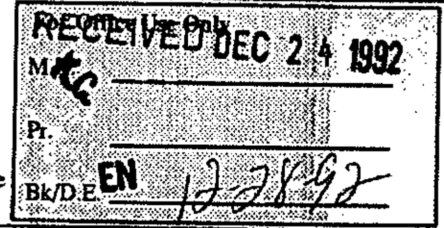
Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1993-1995 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
57680	ACTIVE	$250.00	02/06/93	$25.00

Mailing Address:
YVONNE GOMEZ-CARRION, 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.



Pre-Printed Information

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

   b) Address (Business):
   435 WARREN STREET
   ~~ROXBURY COMP COMM HEALTH~~
   ROXBURY, MA 02119
3. Date of Birth: Sex: F
   Lic. Issue Date: 06/24/87 SS#: - -
   Telephone Number:
   Home Business
   (617)442-7400
4. Name of Medical School:
   Columbia Univ. College of Physicians & Surgeons
   Year Graduated: 83 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr): NY
   b) States where you previously were licensed to practice (Abbr):
6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology
	0	

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: OG 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: 0 If 999 print Country: ____
Address (Business): ____
City/Town: ____
Country Code: 0 If 999 print Country: ____

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

5. a) None
   b) NY

6. Code: ____ Hours per Week in Mass.: 60
   If OS, print specialty: ____

7. a) Code: ____ Code: ____
   b) Code: ____ Code: ____

8. 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: Gomez-Carrion Registration Number: 57880

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: CRICO (HARVARD INSURANCE CARRIER)

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: 69 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

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

If 999, print name(s): ___

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

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

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 25

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? 35 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 25 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:

	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.**

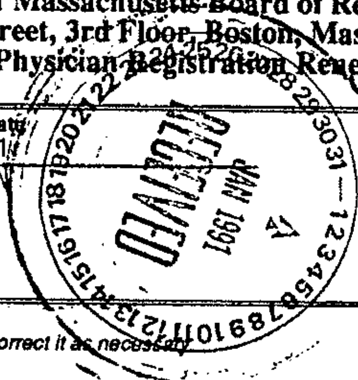
- **Pursuant to G.L. c. 62C, sec. 49A, I hereby certify under the penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state 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: Yvonne Gomez-Carrion MD Date: 12/22/92

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
57380	ACTIVE	$150	02/06/91

Dr. YVONNE GOMEZ-CARRION

For Office Use Only
M.R. ____
Pr. ____ JAN 09
Bk. ____
Ch. ____ JAN 09
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.*

Activity Status:

I am applying to be registered with the following status: Active ✓ Inactive____

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

Pre-Printed Information

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

2. a) Address (Home):

2. b) Address (Business):
435 WARREN STREET
ROXBURY COMP COMM HEALTH
ROXBURY, MA 02119-

3. Date of Birth
Lic. Issue Date: 06/24/87
Sex: F
SSN #: - -
Telephone Number:
Home
Business
(617)442-7400

4. Medical School Code NY001 Year Graduated 83 Degree: MD
Name of School:
Columbia Univ. College of Physicians & Surgeons

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

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

Code	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology
—	0	

7.a) Are you American Specialty Board Certified? (Y/N) N
Code:
Code:

7.b) If YES, Enter Codes:

Corrections of Pre-Printed Information

Name:____
Address:____
City/Town____
State:____ Zip:____
Country Code:____ (If 999 write Country):____
Address:____
City/Town:____
State:____ Zip:____
Country Code:____ (If 999, write Country):____

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

Code	Hours per Week in Mass.

If OS, write specialty:____

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 ✓ 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: Gomez - Carrion Registration No.: 57880

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

List Insurer: Joint Underwriting Association of Massachusetts

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: 69 / ✓ (AP) Facility Code: ____/__(AP) Facility Code: ____/__(AP)

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

If 999, write Name(s):

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

Facility Code:___ 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? 30 hrs./wk. in MA.
b) How many hours per typical week are you currently involved in *inpatient* care in MA? 30 hrs./wk. in MA.

14. Principal Work Setting.
a) What is your principal work setting? *(See Table 6)* 25

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

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

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

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

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

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

Signature: [signature] Date 12 / 31 / 90

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

SOC SEC NUMBER OPTIONAL: ___-__-____

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	
		57880	$100		02	06	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.**

YVONNE GOMEZ-CARRION

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

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

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

1. Print Name: SAME
2. Date of Birth: ____ MONTH ____ DAY ____ YEAR
3. Medical School: COLLEGE OF PHYS & SURG M.D.? ☒ D.O.? ☐ (Check One.)
4. Country where Medical School located: USA
5. Date of Graduation: 1983
6. American Specialty Board Certified? ☐ (Check if yes.)
   Which Boards? ____
7. Principal Specialty(ies): ____
8. Principal work setting: ____
9. Home address: SAME
10. Principal business address: ____
11. List all hospitals at which you have currently effective privileges: ____
12. List all hospitals at which you have held privileges in the past 20 years: ____
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: ____

	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.

SIGNATURE ____

DATE: ____

(See Reverse Side)

A/F

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved:
Disapproved:

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

Filed: 5/15/87
By: [illegible]
Form of Fee: MO

FOR OFFICE USE

Application # 62548
Certificate # 57880 Date of Issue: 6-24-87

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name: Yvonne (First) — (Middle) Gomez-Carrion (Last)

Date of Birth

Place of Birth: Brooklyn, New York

Name on Birth Certificate: Yvonne Gomez-Carrion

Mailing Address:

Phone #

Pre-medical Education

School: Princeton University

Dates Attended: 9/75 - 6/79

Medical Education

School: Columbia University College of Physicians & Surgeons

Dates Attended: 8/79 - 5/83

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

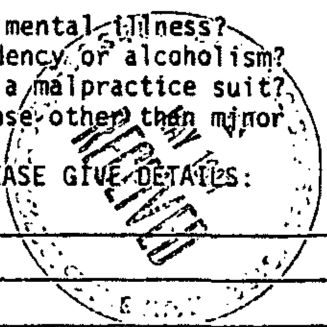
Place	Position	Dates
Columbia Presbyterian	Intern	7/83 - 6/84
Medical Center	2nd/3rd yr Resident	7/84 - 6/86
"	Chief Resident	7/86 - 6/87
	in Obstetrics/Gynecology	

List all other states where you are or have been licensed: —

Are you a Diplomate of a Specialty Board? —
(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:



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.**

RECEIVED DEC 26 1996 BOARD OF REGISTRATION IN MEDICINE

Registration No.: 57880 Renewal Date: 02/06/97

1. Activity Status: (Check only one)
   ☑ 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:

   YVONNE GOMEZ-CARRION, M.D.

   B) Business Address:
   435 WARREN ST
   ROXBURY COMP COMM HEALTH
   ROXBURY, MA 02119-1833

   Home Phone:
   Business Phone: (617)442-7400
4. A) Date of Birth: C) Sex: F
   B) Lic. Issue Date: 06/24/87 D) SS#:
5. A) Name of Medical School:
   Columbia Univ. College of Physicians & Surgeons
   B) Year Graduated: 83 C) Degree: MD
6. Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass.	
OBG	60	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:
City/Town: State:
Zip: Country:

Home: ( )
Business: ( )

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

Year Graduated: Degree (MD/DO):

Code(s) Hours Per Week in Mass.

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: Gomez-Carrion Registration Number: 57880

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: 691/✓(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: United States / Federal Tort Claims Act
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) 25

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

1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 40 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 60 %

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. 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?		1
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 [signature] MD Date: 12/16/96

Commonwealth of Massachusetts Board of Registration in Medicine

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

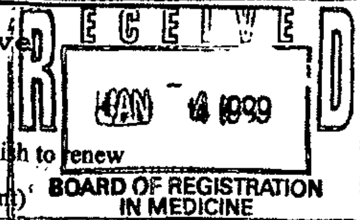
Physician Registration Renewal Application

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.: 57880 Renewal Date: 02/06/1999 1. Current Status: Active



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

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

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

Please make corrections (type or print)

Other Name(s): ____

3. A) Mailing/Home Address:

YVONNE GOMEZ-CARRION, M.D.

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

B) Business Address:
BI DEACONESS HEALTH CARE
2 HARRIS AVENUE
JAMAICA PLAIN, MA 02130

Other Address: ____
City/Town: ____ State: ____
Zip: ____ Country: ____

Home Phone:
Business Phone: (617)524-9270

Home: ( ) ____
Business: ( ) ____

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

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

5. A) Name of Medical School:

Columbia Univ. College of Physicians & Surgeons

B) Year Graduated: 1983 C) Degree: MD

Full Name of Medical School: ____

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

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

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

Code(s) ____ Hours Per Week in Massachusetts ____
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: Gomez-Carrion Registration Number: 57880

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: 1411 / ✓ (AP) 40 % 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: CRICO 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) 1 5

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

1) Average weekly hours involved in: a) outpatient care 30 hrs/wk b) inpatient care 20 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 40 %

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) ☐ Training Program 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: [signature] Date: 12/14/98

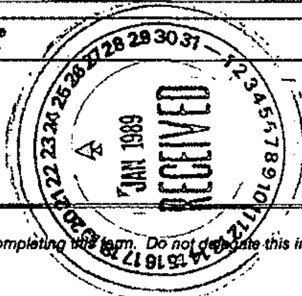
YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2 002468

Board Use Only:

Registration No.	Status	Fee	Renewal Date
57880	1	$150	02/06/89

YVONNE GOMEZ-CARRION



M.R. Cdg 1/28/89
Pr.
Bk. DS 1/30/89
Ch.
D.E. ECN 2/2/89
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:) Gomez- Carrion (FIRST:) Yvonne (M.I.:)

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

2. a) Address (Mailing): (as above)

2. b) Address (Home): as above

2. c) Address (Business): Roxbury Comprehensive Community Health Center 435 Warren Street Roxbury, MA 02119

2. d) Telephone (Business): (612) 442-7400 Extension 239 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)*: NY001 *If 99999, write Name:*

6. b) Year Graduated: 1983 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	35 %	15 Private Office	%	20 Partnership/Group Practice	%
25 Clinic	65 %	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	60 %
30 Administrative Activities	20 %	40 Medical Teaching	20 %
50 Medical Research	%	99 Other	%

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 6/24/87

9. Specialty Code *(See Table 3)*: 086 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: 069 ~~100~~ 35 % Facility Code: ___ % Facility Code: ___ %
Facility Code: ___ % Facility Code: ___ % Facility Code: ___ %

If 999, write Name(s): 999 Roxbury Comprehensive Community Health Center 65%

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

If 999, write Name(s): 999 Columbia Presbyterian Hospital in the City of New York.

*** 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 (#) 0 attached pages—is true.

Signature: Yvonne Gomez-Carrion, M.D. (see reverse side) Date: 1/17/89

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

Fill in name and number. **Physician Last Name:** Gomez - Carrion **Registration No.:** 57880

12. a) Other States where you are now licensed to practice *(Abbreviate)*: NY __ __ __ __ __

12. b) States where you previously were licensed to practice *(Abbreviate)*: __ __ __ __ __ __

13. I am applying to be registered with the following status: ACTIVE ✓ *INACTIVE___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)* Category I: 145 hrs., Category II: 48 hrs., (Risk-Management: 11 hrs.); Residency Program in: ___; Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT___. *If applicable, check one and identify the name.* Insurer: Massachusetts JUA 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
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 – (617) 654-9810 http://www.massmedboard.org

Physician Registration Renewal Application

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

RECEIVED JAN - 2 Board of Registration in Medicine

- **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.: 57880 Renewal Date: 02/06/2003

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:
YVONNE GOMEZ-CARRION

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

Business Address: 2 Harris Avenue
City/Town: Jamaica Plain State: MA
Zip: 02130 Country: USA
Business Telephone: (617) 524-9270

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: Columbia Univ. College of Physicians & Surgeons
b) Year Graduated: 1983 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	50	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: 441 / ✓ (AP) 30 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s):

PRINT YOUR LAST NAME: Gomez-Carrion LICENSE NUMBER: 57880

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: 12/31/03

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) 15 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 30 hrs/wk B) outpatient care 20 hrs/wk
    2) What is the approximate percentage of your patient care hours in primary care? 5 %

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.

Question	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: [signature] Date: 12/27/02

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: YVONNE GOMEZ-CARRION **License No.:** 57880

PART A

1) Current Status: Active **Renewal Due Date:** 01/09/2005 **Birth Date:**

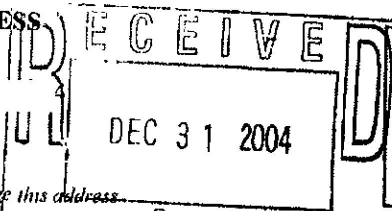
If you want to change your current status, please check *one* of the following boxes to indicate your *new* status: (Check only one). (*See Renewal Instructions, page 3.*)

☐ 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
BI DEACONESS HEALTH CARE
2 HARRIS AVENUE
JAMAICA PLAIN, MA 02130

Phone: (617)524-9270

☑ *Check here to change this address*

Business Address: BIDMC
330 BROOKLINE AVENUE
City/Town: BOSTON State: MA
Zip: 02215 Country: USA
Business Telephone: (617) 667 2952

Business address cannot be a Post Office Box

3) E-mail Address: ____

4) Fax Number: 617 975 5207

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**	**AOA**	**Certificate/Subspecialty**	**Correct?**	**Delete?**
American College of	☑	☐	Obstetrics & Gynecology	☑	☐
Obstetrics & Gynecology	☐	☐		☐	☐
(ACOG)	☐	☐		☐	☐
	☐	☐		☐	☐

Massachusetts Physician Renewal Application

Physician Name: YVONNE GOMEZ-CARRION **License No.:** 57880

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

a) Massachusetts:

b) Federal (DEA):

c) Federal (DEA) XS:

Please make corrections as necessary

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

___ ___ ___ ___ ___ ___ ___ ___

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

___ ___ ___ ___ ___ ___ ___ ___

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

Principal Work Setting: Private Office

Change to: HOSPITAL Hours per Week: 60

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	**Staff Category** Current	Change	**# Hours per Week**
Beth Israel Deaconess Medical Center	☐	Admitting		
Other	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ___ hrs/wk

b) outpatient care 20 hrs/wk Change to: 30 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: CRICO Change to: ________

Policy dates: From 1/1/2005 To 12/31/2005
(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: YVONNE GOMEZ-CARRION **License No.:** 57880

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

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

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

Question	YES	NO
14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?		
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☑ 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: YVONNE GOMEZ-CARRION **License No.: 57880**

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: [signature] Date: 12/28/04

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

Massachusetts Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

PART A

1) Current Status: Active **Renewal Due Date:** 01/09/2007 **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

01/10/07 SS

12

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

2a) MAILING ADDRESS

RECEIVED
JAN 8 2007
Board of Registration in Medicine

☐ *Check here to change this address*

Please make corrections (print)

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
BIDMC
300 Brookline Ave
Boston, MA 02215

Phone: (617)667-2952

☐ *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: 617-975-5207

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

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: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

(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

____ ____ ____ ____ ____ ____ ____

01/10/07 SS 13

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?
Beth Israel Deaconess Medical Center	Boston	MA	☐
Other			☐
			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ____ hrs/wk

b) outpatient care 30 hrs/wk Change to: ____ hrs/wk

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

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

☑ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: CRICO Change to: ______________

Policy dates: From 6/30/06 To 6/30/07

Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy

☐ **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: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

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 a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.: 57880**

PART C

Check One:

PHYSICIAN PROFILE

☑ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: [signature] Date: 12/24/06

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: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

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 5 6 8 0 1 2 9 6 7
- ☐ 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	Ob/Gyn
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): NY Country of Birth (if outside the US): —

Gender: ☐ Male ☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: Date: 12-24-06

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

Massachusetts Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. License No.: 57880

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PART A

1) Current Status: Active Renewal Due Date: 01/09/2009 Birth Date:

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

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

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

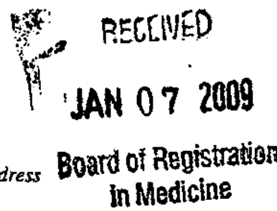
Please make corrections (print)

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
BIDMC
300 Brookline Ave
Boston, MA 02215

Phone: (617)667-2952

☐ *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: 617-975-5207

Correct your E-mail and Fax Number below:

____

____

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: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

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(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?
Beth Israel Deaconess Medical Center	BOSTON	MA	☐
			☐
			☐
			☐
			☐

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 30 hrs/wk Change to: ____ hrs/wk
b) outpatient care 30 hrs/wk Change to: ____ hrs/wk

12) Medical Liability Insurance Information *(See Renewal Instructions, page 5.)*
Check one. Locum tenens must list policy dates. My medical liability insurance is provided through:
☑ **Insurance Carrier** ***(complete below)***
Current Insurance Carrier: CRICO Change to: ____
Policy dates: From 1/1/09 To 12/31/09
Type of Policy: ☐ Claims made with tail coverage ☑ Occurrence Policy
(Enclose a copy of the certificate of insurance or the face sheet)
☐ **Letter of Credit subject to Board approval** ***(Attach a copy.)***
☐ **I am registering with Active status but I am not required to have medical liability insurance because I am:**
Check one: ☐ Not involved with direct or indirect patient care in Massachusetts
☐ A Government Employee under Federal Tort Claims Act (FTCA)
☐ Otherwise exempt *(Please explain)*: ____

13) Do you perform any surgery in your Massachusetts office? *(See Renewal Instructions, page 5.)* **Yes** **No**
If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

Massachusetts Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.: 57880**

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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 a) **NEW:** Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.: 57880**

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PART C

Check One: **PHYSICIAN PROFILE**

☐ I have reviewed my Physician Profile at http://profiles.massmedboard.org and confirm that the information is accurate. (Please note that if you changed or corrected your business address, business phone number, practice specialty, board certification and/or hospital affiliations on your renewal application, your Physician Profile will also be updated.)

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Yvonne Gomez-Carrion Date: 12/3/08

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.

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• online services • agencies

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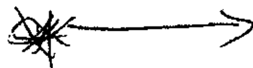
Massachusetts Board of Registration in Medicine Physician Profile

Yvonne Gomez-Carrion, M.D.

I. **Physician Information**

(The information in sections I - VI has been provided by the physician.)

License Status: Active
License Issue Date: 6/24/1987
Accepting New Patients: Yes
Accepts Medicaid: Yes
Primary Work Setting: Hospital
Business Address: BIDMC
300 Brookline Ave
Boston, MA 02215
Phone: (617) 667-2952



Translation Services Available: ~~Spanish~~ All languages, including ASL
Insurance Plans Accepted: Numerous Plans Accepted
Hospital Affiliations: Beth Israel Deaconess Medical Center

II. **Education & Training**

Medical School: Columbia Univ. College of Physicians & Surgeons
Graduation Date: 1983
Post Graduate Training: Columbia University Med Ctr (7/1/1983-6/1/1987)

III. **Specialty**

Area of Specialty: Obstetrics and Gynecology

IV. **Board Certifications**

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty

Obstetrics & Gynecology Obstetrics and Gynecology

V. **Honors and Awards**

1995 Roxbury Comprehensive Community Health Center
2003-BidMc ob/gyn Teachning Award
2007 - PINE MANOR COLLEGE - HONORARY BS DEGREE
2008 - BIDMC / MLK BLACK ACHIEVER AWARD

VI. **Professional Publications**

Reducing The Risks Of Atrial Fibrulation, Contempo
Rary Obstetrics And Gynecology, 1991
Preventative Health Services Received By Minority
Women Ages 45-64 And The Guals Of Health People
2000 Women'S Health Issues Vol 10 Number 6 Nov/dec

VII. **Malpractice Information**

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be

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construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

Dr. Gomez-Carrion has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

Dr. Gomez-Carrion has had no criminal convictions in the past ten years.

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

Dr. Gomez-Carrion has no record of hospital discipline in the past ten years.

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

Dr. Gomez-Carrion has not been disciplined by the Board in the past ten years.

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 781-876-8230
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search

Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Phone 781-876-8200
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

Current Status: Active **License Expiration Date:** 2/6/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
BIDMC
300 Brookline Ave
Boston
Massachusetts - 02215
United States of America
(617) 667-2952

3) **Email Address:**

4) **Fax Number:** (617) 975-5207

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
Beth Israel Deaconess Medical Center Other	Boston

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

11) Care of patients in Massachusetts
Average weekly hours involved in:
a) inpatient care 34 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2010	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, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

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: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

Current Status: Active **License Expiration Date:** 2/6/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

BIDMC
330 Brookline Ave
Boston
Massachusetts - 02215
United States of America
(617) 667-2952

3) **Email Address:**

4) **Fax Number:** (617) 975-5207

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
Beth Israel Deaconess Medical Center Other	Boston

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

11) Care of patients in Massachusetts
Average weekly hours involved in:
a) inpatient care 34 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	**Policy Start Date**	**Policy End Date**	**Policy Type**
CRICO	01/01/2012	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?

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Yvonne Gomez-Carrion, M.D. **License No.:** 57880

Current Status: Active **License Expiration Date:** 2/6/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
BIDMC
330 Brookline Ave
Boston
Massachusetts - 02215
United States of America
(617) 667-2952

3) **Email Address:**

4) **Fax Number:** (617) 975-5207

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
Beth Israel Deaconess Medical Center Other	Boston

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 10 hrs/wk
b) outpatient care 40 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2014	12/31/2015	Claims made with tail coverage

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

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

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

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

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

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

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

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

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

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?

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

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

PETER N. MADRAS, M.D.
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MARTIN CRANE, M. D.
DOROTHY KEVILLE, M.Ed
ROSCOE TRIMMIER, Esq.
REGIS DE SILVA, M.D.

09/04/08 83

May 22, 2002

REDACTED COPY

Yvonne Gomez-Carrion, M.D.

Re: Complainant:
Docket No.: 01-507

Dear Dr. Gomez-Carrion:

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

The Committee also determined that no further action was warranted and the complaint was closed. If you have any questions, please call Janet Ritsko of the Clinical Care Unit at 617-727-3086, ext. 380.

Very truly yours,

Peter Madras, M.D.
Member, Complaint Committee

Commonwealth of Massachusetts
Board of Registration in Medicine

10 West Street
Boston, Massachusetts 02111

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DOROTHY KEVILLE, M.Ed
ROSCOE TRIMMIER, Esq.
REGIS DE SILVA, M.D.

May 22, 2002

Re: Yvonne Gomez-Carrion, M.D.
Docket No.: 01-507

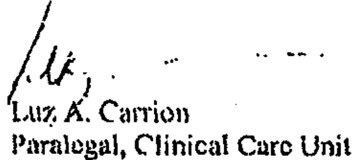
Dear

The Complaint Committee of the Board of Registration in Medicine met on May 22, 2002 and carefully considered the information you furnished regarding your complaint. Your complaint, the physician's response, and the medical records were thoroughly reviewed.

The Committee has decided to close this docketed complaint . Additionally, the Committee wants you to know that these documents have been placed in Dr. Gomez-Carrion's permanent record.

The Committee members appreciate your efforts in bringing this matter to their attention. If you have any questions please feel free to contact me at (617) 727-1788 Ext. 368.

Very truly yours,



Luz A. Carrion
Paralegal, Clinical Care Unit

Enclosure

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street
Boston, Massachusetts 02111

(617) 727-3086
Fax: (617) 451-9568
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DOROTHY KEVILLE, M.Ed
ROSCOE TRIMMIER, Esq.
REGIS DE SILVA, M.D.

October 10, 2001

Yvonne Gomez-Carrion, M.D.

Re:
Docket Number: 01-507

Dear Dr. Gomez-Carrion:

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

Please provide both a written response to the issues raised in the enclosed material and a copy of the patient's medical records. Your response may be as brief or as lengthy as you choose. Under the law, the person filing the enclosed complaint may have access to your response.

Your response should be sent to the Consumer Protection Coordinator, at the address above, within 30 days of your receipt of this letter. After your response is received, the case may be assigned to an investigator employed by the Board, who may contact you if further information is needed. You will, in any event, be informed in writing as to the disposition of this complaint. Thank you for your attention to this matter.

Very truly yours,

Kathleen M. Shea

Kathleen M. Shea
Consumer Protection Manager

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

JANE SWIFT
GOVERNOR

NANCY ACHIN SULLIVAN
EXECUTIVE DIRECTOR

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MARTIN CRANE, M. D.
DOROTHY KEVILLE, M.Ed
ROSCOE TRIMMIER, Esq.
REGIS DE SILVA, M.D.

October 10, 2001

Re: Yvonne Gomez-Carrion, M.D.
Docket Number: 01-507

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 the Consumer Protection Department at the address above.

Very truly yours,

Kathleen M. Shea

Kathleen M. Shea
Consumer Protection Manager

03/04/08 03

December 19, 2001

Kathleen M. Shea
Consumer Protection Manager
Board of Registration in Medicine
10 West Street
Boston, MA 02111

Re:
Yvonne Gomez-Carrion, M.D.
Docket No: 01-507

Dear Ms. Shea:

This is in response to the Complaint that was filed by

I was obstetrician/gynecologist for the pregnancy in question.

first visit with me for this pregnancy was , 2001. At that time, she was nine weeks pregnant. My examination revealed that she had a small polyp on her cervix and no bleeding. was slightly anemic with a hematocrit of 35.7.

My second visit with was on 2001. She was approximately twelve weeks gestation. It was during this visit that I discussed with the option of amniocentesis. wished to have an amniocentesis and I discussed with her the possible risks of rupture of membranes, infection, and loss of fetus.

On , 2001, I performed an ultrasound and amniocentesis on . The amniocentesis was uneventful. The ultrasound indicated a gestational age of 16.3 weeks and the amniocentesis results were normal.

On , 2001, called my office to report a light pink vaginal discharge with mild cramping. We made arrangements for her to be examined on 2001 in my office. complained of nausea. cervix appeared to be an appropriate length, there was no cervical dilation and no fluid leakage. She had a pink to dark brown discharge with no chills or fever. Her white blood cell count was normal. Clue cells were present. I prescribed Flagyl for a probable bacterial vaginosis based on clinical findings. Flagyl is an appropriate drug for a pregnant woman with bacterial vaginosis.

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On , 2001, I called to report that her amniocentesis was within normal limits. reported that she was feeling better and she no longer had vaginal discharge or cramping.

On , 2001, called to report that although she was feeling better with no cramping, she was still spotting with pink and red discharge. We arranged to examine her that day.

My , 2001 examination revealed some pink to light red discharge. cervix was long, closed, but friable. The small polyp noted on initial visit of , 2001 remained present, however now with a small area of bleeding. This is not uncommon for a cervical polyp. I cauterized it with silver nitrate. After the cauterization, homeostasis was excellent. The spotting was reduced. had no fever or chills. I performed a wet prep and there was no infection present. Her bacterial vaginosis appeared to be resolved. We arranged for her to be seen on , 2001.

On , 2001, during a routine fetal survey, a vaginal ultrasound was performed and revealed a shortened cervix, measured at approximately 1.8 centimeters.

I spoke was both and her husband about my concerns with her shortened cervix and showed them pictures form the *William's* textbook regarding cervical shortening. I explained to them that fetal loss was a risk from cervical shortening and the options for treating this was complete bed rest except for going to the bathroom or the placement of a cervical cerclage. I discussed with and her husband the risks and benefits of a cervical cerclage including the possible rupture of membranes, uterine cramping, and loss of fetus. The risks of cerclage placement far outweighed the risks from the procedure. The vaginal ultrasound of , 2001, had demonstrated that cervix was insufficient indicating a high likelihood of a miscarriage, if left untreated. signed a consent form, acknowledging this discussion.

Allowing the patient time to consider her management options did not change the risk of infection from the cerclage. Prior to , 2001, 's cervix showed no evidence of dilatation and her bacterial vaginosis had resolved. I performed a wet prep to confirm that no longer had clue cells present.

On 2001, I placed a cervical cerclage at the Beth Israel Deaconess Medical Center. history of bacterial vaginosis did place her at a higher risk for infection. However, I did check for an infection prior to the placement of the

03/04/08 03

cerclage and none was present. My intraoperative exam revealed a 2.0 cm external cervix.

underwent a cervical cerclage without incident. Following this procedure, was monitored in the recovery room for approximately seven hours for cramping and/or fluid leakage. had stable vital signs and no fluid leakage. was discharged home with her husband with discharge instructions to call if she had bleeding, cramping, or other concerning symptoms. She was instructed to reduce her activity for twenty-four hours.

The placement of the cerclage is done as a same day surgery and does not require patients such as to stay in the hospital longer than that unless there are specific complications either intraoperatively or immediately postoperatively. The cerclage was placed in with no complication and she had no signs of complications during the initial seven hours following the surgery. Long term reduction of a woman's usual activities is not necessary after cerclage placement.

Following this type of procedure, it is expected that the patient will experience postoperative staining and/or cramping.

We have a telephone system in place at our office to handle telephone calls from patients. The secretaries are given a logarithm regarding a patient's symptoms and ask the patient if it is an emergency. When the secretaries receive a telephone call from a patient, they place the message on email. My Nurse Manager responds to the email and a copy of her response is placed in the patient's medical record.

It is my understanding that the spoke with my colleague, on 2001. Since answered the telephone directly, there is no message from a secretary. However, it is not unusual to have a discharge with light bleeding following cerclage placement. Based on description of her symptoms, it was clinical judgment that no further assessment was necessary at this time. Instructions for concerns were again reviewed.

I was on vacation from .001 until 2001. Based on our review of office telephone messages, a message was taken from on 2001 at 11:23 a.m. indicated that it was not urgent but that she wanted reassurance. Therefore, the secretary did not page who was not in the office. accessed her emails from home and called later in the day. reported a watery discharge, a symptom that does need clinical evaluation after

09/04/08 03

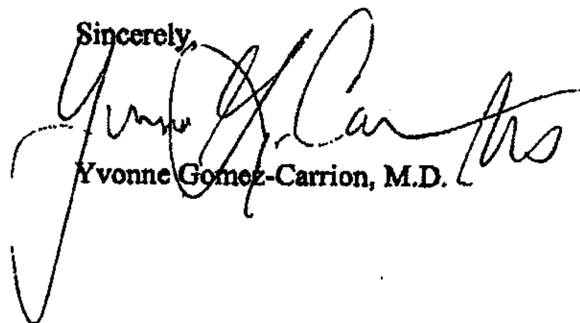
placement of a cerclage. ı instructed ı ı that she needed to be examined by a physician and instructed I to go to the hospital.

There is no recording of any telephone calls from the on , and does not believe that she spoke with them via telephone other than y 2001 when her assessment dictated that ı needed to triage at the hospital.

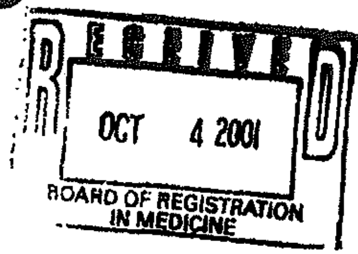
I called the when I returned from vacation to express my condolences and made arrangement to examine on , 2001. Her clinical exam and laboratory findings were within normal limits with the exception of a mild anemia. I never indicated to the that did not act appropriately when they called on 2001. Rather, I assured them I would review the events of the telephone call which I did and found it to have been appropriately handled.

If you need further information, please do not hesitate to contact me.

Sincerely,



Yvonne Gomez-Carrion, M.D.



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 Zip Code

Business/Daytime Phone Home Phone

Complaint against M.D. _____, D.O. _____, Acupuncturist _____.

(For complaints against Chiropractors, Dentists, Nurses, Optometrists, Podiatrists or Psychologists, please contact the Division of Registration at (617)727-7406, or 239 Causeway St., 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.

Yvonne Gomez-Carrion

Address

2 Harris Ave.

City: Boston State: MA Zip Code: 02130

Business Phone: (617) 524-9270

Name and Location of Health Care Facility (if known)

Beth Israel Health Care

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 Pati ______________________ Date: 10/1/01
(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:** ____________
(Or Legal Representative)

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

Yvonne Gomez-Carrion, Beth Israel Healthcare
2 Harris Ave., Boston, MA 02130 (617)524-9270

Beth Israel Hospital, 330 Brookline Ave., Boston, MA

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

Is this physician the person you (or patient) usually see when you (or patient) are ill?
☐ Yes, ☒ No

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: April 11 – July 13, 2001.

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

See attached

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: 10/1/01

Mail this form to:

Consumer Protection Coordinator
Board of Registration in Medicine
Ten West Street, Third Floor
Boston MA 02111

09/04/08 63 12

October 1, 2001

Consumer Protection Coordinator
Board of Registration of Medicine
Ten West St. Third Fl.
Boston, MA 02111

Re: Questions about the prenatal care received from Dr. Gomez-Carrion and Beth Israel Hospital

We believe that there were serious errors in how Dr. Gomez-Carrion and Beth Israel Hospital provided prenatal medical care to . and would like to bring them to your attention.

began to see Dr. Gomez-Carrion for her prenatal care on 2001 at the Beth Israel Health Center in Jamaica Plain. She delivered a premature stillborn infant o. , 2001. She and her husband, ., believe Dr. Gomez-Carrion provided substandard care by:

1) Inaccurately diagnosing and treating symptoms of bleeding and cramping when they first occurred during the 17th week of gestation. was told she had vaginosis, and shortly thereafter, an incompetent cervix. Treatment included use of Flagyl and placement of a cerclage suture. The clinical evidence of vaginosis was not clear. The fact that bleeding was usually considered a contraindication for placing a cerclage was not acknowledged or discussed. Our understanding is that the placement of the cerclage in this situation significantly increased the likelihood that an infection was introduced that ultimately killed the baby.

2) Not testing for infections prior to a cerclage operation, in spite of the fact that such pre-operative tests are considered standard protocol by many obstetricians.

3) Not following up after the cerclage operation, despite five phone calls to Dr. Gomez-Carrion's office by la and describing a change in vaginal discharge. On the last phone call, which took 7 hours to return, was advised to go to Beth Israel Hospital. When she was admitted that night, there was virtually no amniotic fluid and an elevated white blood cell count. The attending doctor recommended terminating the pregnancy the next morning.

4) Not documenting patient phone calls. None of the above phone calls were recorded in file. The medical records from the clinic were presented to at Beth Israel Hospital o /01 prior to delivery of the baby.

We believe Beth Israel Deaconess Medical Center (BIDMC) provided substandard care by:

1) Not providing appropriate administrative and clinical supervision of Dr. Gomez-Carrion or of their clinic in Jamaica Plain.

2) Not requiring tests for infection prior to a cerclage operation done at their hospital.

3) Not requiring a post-cerclage follow-up call from the staff of day surgery and an appointment with a doctor for an examination and ultrasound within a few days of the operation.

4) Not releasing the baby's body from the morgue until four days after the death.

We raised our concerns with both Dr. Gomez-Carrion and , the Director of OB/GYN at Beth Israel Deaconess Medical Center. Dr. Gomez-Carrion believed she provided adequate care. acknowledged "miscommunication" between Dr. Gomez-Carrion and us. However, he said that neither she nor the hospital did anything wrong. However, after meeting with other doctors, and reading recent medical literature, we believe the care we received was substandard.

indicated that he served on the Board of Medicine to review cases in obstetrics. Because he is also representing Beth Israel Hospital, we would ask that he not be involved in this case.

Our goal is to insure that learning occurs so that another tragedy such as the one that befell our son, , does not recur. To this end, we would like to know, in writing, what changes Dr. Gomez-Carrion and Beth Israel Medical Center will make to improve their prenatal care.

Thank you.