Commonwealth of Massachusetts Board of Registration in Medicine

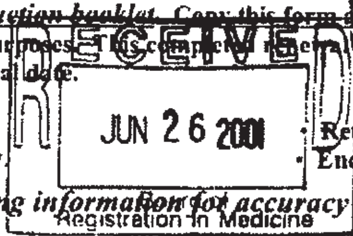
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

COMPLETED

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

REDACTED 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.**

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

1. Current Status: Active Registration No. 209257 Renewal Date: 07/23/2001

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:
Daniela A Carusi

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): ______

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

Business Address: 75 Francis St
City/Town: Boston State: MA
Zip: 02130 Country: USA
Business Telephone: (617) 732-6660

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:
University of California School of Medicine, SF

b) Year Graduated: 1997 c) Degree: M.D.

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

OBG 0 Obstetrics and Gynecology
0

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

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

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

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

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

Facility Code: 921/✓ (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): ______

PRINT YOUR LAST NAME: Carusi LICENSE NUMBER: 209257

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 0

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

1) Average weekly hours involved in: a) outpatient care 25 hrs/wk b) inpatient care 25 hrs/wk

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

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

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

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

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

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

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

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

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

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: Daniela Carusi Date: 6/21/01

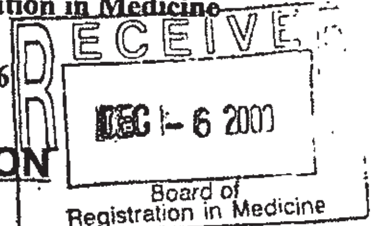
YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

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

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

Application #: 209259
Date of Issue: ______

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor
Boston, MA 02111 - (617) 727-3086



FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

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

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

CARUSI	DANIELA	ANNE	
Last Name (type or print clearly)	First	Middle	Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree ______

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

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

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

Place of Birth: MOUNTAIN VIEW (City) CALIFORNIA (State/Province/Territory) Country if not USA

Home Address: ______ Number and Street

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

Business Address: BRIGHAM + WOMEN'S HOSPITAL, 75 FRANCIS ST
Number and Street

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

Business Telephone: (617) 732-6660, ext. 31222 Home Telephone: ______

Preferred Mailing Address: ☒ Business Address ☐ Home Address

1125
12/6/00 (AO)

APPLICANT'S NAME: DANIELA CARUSI

Pre-medical School

			From	To
Facility: University of California, Los Angeles	Degree: B.S.		9/1/87	9/11/1992
Street: 405 Hilgard Ave	City: Los Angeles	State: CA		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: University of California, San Francisco	Degree: M.D.		9/7/92	5/23/97
Street: Millberry Union, Room 200	City: San Francisco	State: CA		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 5/23/97

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

See attached addendum

Postgraduate Education:

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

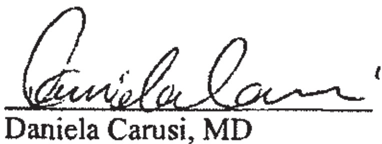
			From	To
Facility: BRIGHAM & WOMEN'S HOSPITAL	Position: PGY 1-4		6/25/97	6/22/01
Street: 75 FRANCIS ST	City: BOSTON	State: MA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

November 27, 2000

This addendum addresses my medical education lasting longer than four years, as requested on Page 2 of the application.

I attended the University of California, San Francisco, for a total of five years in pursuit of my M.D. After completion of the standard curriculum for the first 3 years, I elected to complete an additional year of research. During this year I remained enrolled as a full-time student at UCSF. I initiated and completed a clinical research project, which culminated in a formal thesis and a publication. I also continued to see patients 1-2 days per week in an ambulatory practice as well as in a volunteer community health clinic. When the project was completed, I resumed my final standard year of medical school.

Though I extended my education from four years to five, there were no breaks in my medical education.



Daniela Carusi, MD

APPLICANT'S NAME: DANIELA CACUSI

Hospital Affiliations and Employment

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

			From	To
Facility: BRIGHAM & WOMEN'S HOSPITAL	Position: PGY 1-4		06/25/97	06/22/00
Street: 75 FRANCIS St	City: BOSTON		State: MA	
Facility: MASSACHUSETTS GENERAL HOSPITAL	Position: PGY 1-4		06/25/97	06/22/00
Street: 32 FRUIT St	City: BOSTON		State: MA	
Facility:	Position:		/ /	/ /
Street:	City:		State:	
Facility:	Position:		/ /	/ /
Street:	City:		State:	

1. List other states (abbreviations) where you are currently or have ever been licensed: ___ ___ ___

2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No

3. List Board Certification(s): ______

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

5. Reason for requesting a Massachusetts medical license: I plan to continue practicing Medicine as an OB/Gyn in Massachusetts

6. Name of Facility: BRIGHAM & WOMEN'S HOSPITAL

7. Address: 75 FRANCIS ST City: BOSTON

8. Anticipated starting date in Massachusetts: 07/01/00

Affidavit of Applicant

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under the penalties of perjury.

[signature]
Signature of Applicant

11/11/00
Date

Commonwealth of Massachusetts Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

STATE LICENSE VERIFICATION

Applicant's Instructions: Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were licensed in the past.

Applicant's Waiver for Release of Information:

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registation in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: [signature] Date: 12/01/00

Print or type name: Daniela Carusi

License number: 97-5802-01 Status of license: ☒ Active ☐ Inactive ☐ Other ____
Massachusetts

TO BE COMPLETED BY STATE BOARD

1. Name of medical school of graduation ____
2. Date of graduation: ___/___/___ License number: ____ Date of issue: ___/___/___
3. Basis for licensure: ____
   Name(s) of medical licensing examinations(s).
4. Expiration date of license: ___/___/___
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: ____

	YES	NO
7. Has the licensee ever been on probation?	☐	☐
8. Has the licensee ever been requested to appear before the board?	☐	☐

If "yes," please explain: ____

Other derogatory information: ____

Remarks: ____

BOARD SEAL

Signed: ____

Print Name: ____

Title: ____

State Board: ____ Date: ___/___/___

PLEASE RETURN DIRECTLY TO THE MASSACHUSETTS BOARD OF REGISTRATION

Commonwealth of Massachusetts - Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

MALPRACTICE HISTORY

Applicant's Instructions: Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. Please return the form(s) with your original signature to the Board of Registration in Medicine.

Waiver for Release of Information

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier.

NOTE: IF THE APPLICANT HAS ANY OPEN OR CLOSED CASES WHERE MONIES HAVE BEEN PAID, A COPY OF THE COMPLAINT OR SUMMONS, DISPOSITION OR JUDGEMENT AND AMOUNT OF MONIES PAID ON BEHALF OF THE APPLICANT MUST BE FOWARDED DIRECTLY TO THE BOARD.

Dates of Issue

Liability Carrier: The Risk Management Foundation, Controlled Risk Insurance Co, Ltd. **From:** 6 / 92 **To:** 07/01
City: Cambridge State: MA
Policy Number: CRC10024 BWH

Liability Carrier: ______ **From:** __/__ **To:** __/__
City: ______ State: ______
Policy Number: ______

Liability Carrier: ______ **From:** __/__ **To:** __/__
City: ______ State: ______
Policy Number: ______

Please forward the information requested to the Board of Registration in Medicine at the address above.

Signed: Daniela Cami 11/1/00
Date

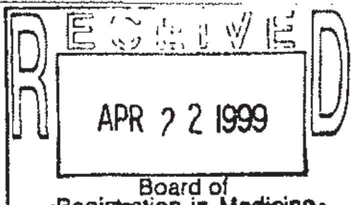
Print Name: Daniela Camsi

Name: Daniela Carusi

Supplemental information for question #12: Medical School Training

I added one year to my medical school training, thus completing my medical school education in five years. During this additional year, I remained enrolled in my medical school (the University of California, San Francisco) and conducted a clinical research project in the department of Obstetrics and Gynecology. The entire year was devoted to designing and implementing the study, which culminated in a thesis overseen by the school's MD with Thesis Committee.

DATE: 4/22
INITIAL: LLS
FEE: $50.00 Check 331



Application #: 97-5802-01
Date Approved: 4/29/1999

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS A AND C ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT.

Section A:

1. Name: (Last) CARUSI (First) DANIELA (MI) A
2. Mailing Address: ______ Telephone Number: ______
   City, State and Zip: ______
3. Name of Training Hospital: BRIGHAM & WOMEN'S HOSPITAL
4. Current Limited License Number: 97-5802-01
5. Other states (abbreviations) where you are now fully licensed to practice medicine: ______

Section B: **To be completed by program director.**

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Robert L. Barbieri, M.D. Date: 4/12/99

Signature of Program Director: Robert Barbieri Telephone: (617) 732-5444

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that DANIELA CARUSI (Name of Applicant) has been appointed to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY______

Program Name: OB/GYN Facility: BRIGHAM & WOMEN'S HOSPITAL

Beginning Date: 6/20/97 Anticipated Completion Date of Training: 6/30/01

Is the program accredited by the ACGME: ☒ Yes ☐ No

If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Shawn Vannier, Manager, Graduate Medical Education (Print Name) (Title) Telephone: 617-732-8540

Designated Official's Signature: Shawn M Vannier Date: 4/16/99

NAME: Daniela Carusi

SECTION C: **Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.**

YES NO

SINCE YOUR LAST RENEWAL

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?

19. Have you voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

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

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

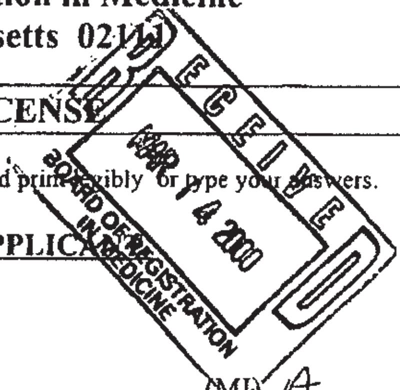
28. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

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

Pd 3/30/00 Ck# 407 $50 [illegible]

Application #: 5802
Date Approved: 3/30/00

Commonwealth of Massachusetts - Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111



RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTIONS "A" AND "C" ON PAGE 2 ARE TO BE COMPLETED BY APPLICANT

SECTION A:

1. Name: (Last) CARUSI (First) DANIELA (MI) A
2. Mailing Address: ______ Telephone Number: ______
   City: ______ State: ______ Zip: ______
3. Name of Training Hospital: BRIGHAM & WOMEN'S HOSPITAL
4. Current Limited License Number: 97-5802-01
5. Other states (abbreviations) where you are now licensed to practice medicine. Indicate whether full license (F) or residency or training license (L). ____ ☐(F) ☐(L) ____ ☐(F) ☐(L) ____ ☐(F) ☐(L)

SECTION B: To be completed by program director.

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: Robert L. Barbieri M.D. Date: 3/8/2000

Signature of Program Director: [signature] Telephone: 617.732.5444

To be completed and signed by the designated official of the institution at which the applicant has received an appointment.

This certifies that Daniela Carusi (Name of Applicant) has been appointed

to the position of: ☐ Intern ☒ Resident ☐ Fellow as a PGY ______

Hospital Name: BRIGHAM & WOMEN'S HOSPITAL Specialty: OB/GYN

Beginning Date: 6/20/97 Anticipated Completion Date of Training: 6/30/01

Is the program accredited by the ACGME: ☒ Yes ☐ No
If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: Shawn Vanner, Manager (Print Name) Graduate Medical Education (Title) Telephone: 617-732-8540

Designated Official's Signature: [signature] Date: 3/10/00

NAME: DANIELA CARUSI

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

YES NO

SINCE YOUR LAST RENEWAL

Note: These questions apply only since your last renewal.

16. Have you been terminated, granted a leave of absence, withdrawn or had to repeat a year in a postgraduate-training program?

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?

19. Have you voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

21. Has any disciplinary action been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition).

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

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24. Have you voluntarily relinquished medical staff membership?

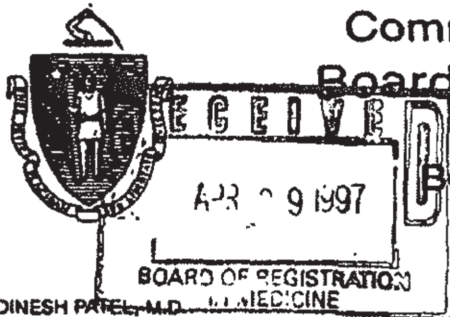
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine

LIMITED
FORM E

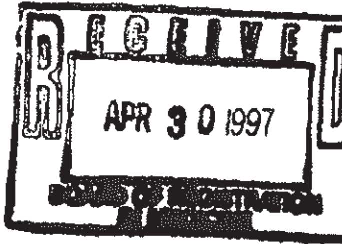
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation



VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it DIRECTLY TO THE ADDRESS ABOVE. This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT Daniela Anne Carusi CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

University of California, Los Angeles
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: University of California, San Francisco
NAME OF MEDICAL SCHOOL

San Francisco, California
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT Daniela Anne Carusi
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 5 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: University of California, San Francisco
NAME OF MEDICAL SCHOOL

CONTINUED ON BACK OF THIS PAGE

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

Commonwealth of Massachusetts
Board of Registration in Medicine

LIMITED

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

FORM E CONTINUED

An Agency within the Executive Office of Consumer Affairs and Business Regulation

NAME OF APPLICANT Daniela Anne Carusi

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

	MONTH	DAY	YEAR		MONTH	DAY	YEAR
FROM:	09	07	92	TO:	06	15	93
FROM:	09	01	93	TO:	06	30	94
FROM:	07	01	94	TO:	06	30	95
FROM:	07	01	95	TO:	06	30	96
FROM:	07	01	96	TO:	06	08	97
FROM:				TO:			
FROM:				TO:			

AND HAS RECEIVED/WILL RECEIVE A DEGREEE OF Medical Doctor

ON June 8 19 97 .

Emilie HS Osborn M.D.

SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Emilie H.S. Osborn, M.D., Associate Dean

NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE: April 25, 1997

Application #: 97-5802-01
Date Approved: 4/14/98

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, Third Floor, Boston, Massachusetts 02111

RENEWAL APPLICATION - LIMITED LICENSE

IMPORTANT: Please read the accompanying instructions before completing this form, and print legibly or type your answers.

SECTION A: Sections A and C on page 2 are to be completed by applicant.

1. Name: (Last) CARUSI (First) DANIELA (MI) A
2. Mailing Address: ______ Telephone Number: ______
   City, State and Zip. ______
3. Name of Training Hospital: BRIGHAM & WOMEN'S HOSPITAL
4. Current Limited License Number: 97-5802-99
5. Other states (abbreviations) where you are now fully licensed to practice medicine: ______

TO BE COMPLETED BY PROGRAM DIRECTOR

Has the physician been subject to past or pending disciplinary action in this program? ☐ Yes ☒ No

I hereby certify that the above-named physician is in good standing in the training program.

Print Name: ROBERT BARBIERI Date: 4/2/98

Signature of Program Director: [signature] Telephone: 7324265

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Daniela A. Carusi (Name of Applicant) has been appointed to the

position of: ☐ Intern ☒ Resident ☐ Fellow

Program Name: Ob/Gyn Facility: Brigham & Women's

Beginning Date: 6/20/97 Anticipated Completion Date of Training: 6/20/01

Is the program accredited by the ACGME: ☒ Yes ☐ No
If no, is there an approved ACGME program in applicant's specialty? ☐ Yes ☐ No

Designated Official: [signature] Telephone: 617-732-8540
(Print Name) (Title)

Designated Official's Signature: Shawn Vanner Graduate Medical Education Program Administrator Date: ______

DATE: 4/8/98
INITIAL: RAK
FEE: $50.00 Check

NAME: DANIELA CARUSI

SECTION C: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on Limited Supplement attached.

YES NO

SINCE YOUR LAST RENEWAL

16. Have you been granted a leave of absence or withdrawn from a post-graduate training program ?

17. Have you been denied the privilege of taking or finishing an examination or have you been accused of cheating or improper conduct during an examination?

18. Have you, for any reason, been denied a medical license, whether full, limited or or temporary or have you withdrawn an application for medical licensure?

19. Have you voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (national, international, state or local)?

21. Has any disciplinary action (see definition) been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

22. Have you been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

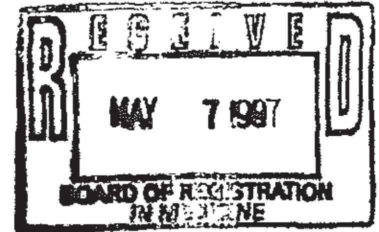
26. Have you been charged with any criminal offense, other than a minor traffic offense?

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

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

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

LTD# 97-5802-99



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

INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a $50 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

☒ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
☐ Graduate of an International Medical School (IMG)
☐ Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

1-A. Name: (Last) CARUSI (First) DANIELA (MI) A

1-B. Other Name(s)

	YES	NO
1) Have you ever been known under a different name or combination of names?	☐	☒
2) Have you ever been licensed under a different name?	☐	☒
3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name?	☐	☒

If yes, you must provide additional information. (See instructions.)

2. Current Residence: ______ Telephone Number ______

3. Date of Birth (Mo/Da/Yr): ______ Place of Birth: MOUNTAIN VIEW, CA

4. Sex: Male ____ Female X 5. Social Security Number: ______

6. Name and address of Massachusetts Training Hospital: Brigham and WOMEN'S HOSPITAL, 75 FRANCIS ST, ASB 1-3-023, BOSTON, MA 02115

7
50-(4)

NAME: Daniela Carusi

7. Name of premedical school(s) University of California, Los Angeles
Location: Los Angeles, California, USA
(City, State, Country)

8. Name of medical school(s) University of California, San Francisco
Location: San Francisco, California, USA
(City, State, Country)
Year of Graduation 1997 Degree Received: M. D. ☒ D. O. ☐ Other (specify)________

9. Have you had previous post-graduate training? Yes ☐ No ☒ U.S. ☐ International ☐

Name of Institution: ________________

Address: ________________

Name of Program: ________________ Dates of Training:________

(If additional space is needed, please continue your answer on a separate sheet of paper.)

10. List states (abbreviations) where you are currently licensed to practice medicine:

_____ _____ _____ _____ _____

11. List states (abbreviations) where you were previously licensed to practice medicine (include residency training licenses):

_____ _____ _____ _____ _____

12. Medical School Training:

YES NO

a) If you are a USMG, have you taken more than 4 years to complete medical school?
b) If you are an IMG, have you taken more than 6 years to complete medical school?
If yes, you must provide additional information. (See instructions.)

13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?
If yes, you must provide additional information. (See instructions.)

NAME: DANIELA CARUSI

YES **NO**

14. Have you ever been enrolled in a residency training program(s) that you did not complete? **If yes, a letter from your program director is required.** (See instructions.)

    Explanation attached?______ Program Director's Certification requested? _____

SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.

YES **NO**

15. Since your matriculation in college, have you been subject to any disciplinary action (see definition) at any academic institution?

16. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical post-graduate training program?

17. Since your matriculation in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?

18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?

19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

20. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

NAME: DANIELA CARUSI

YES **NO**

21. Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

22. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

24. Have you ever voluntarily relinquished medical staff membership?

25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

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

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

28. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

29. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

NAME: DANIELA CARUSI

SECTION C: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Daniela A. Carusi, MD has been appointed
(Name of Applicant)

to the position of ☐ Intern ☑ Resident ☐ Fellow

in the Obstetrics / Gynecology
(Name of Program)

at BRIGHAM & WOMEN'S HOSPITAL
(Name of Hospital)

beginning 6 / 20 / 97 (date) to anticipated completion of training: 6 / 30 / 01 (date).

	YES	NO
Is the program accredited by the ACGME?	☑	☐
If no, is there an ACGME-approved training program in the applicant's specialty?	☐	☐

Designated Official's Signature: Shawn M Vanner

Type or Print Name and Title: Shawn Vanner ~~Graduate Medical Education~~ Program Administrator

Date: 5 / 5 / 97 Telephone Number: 617-732-8540

SUPPLEMENT FORM

Name: Daniela Carusi **Date:** 11/11/00

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

YES NO

1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?

2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?

3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:________________

4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?

5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?

6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?

6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

7. Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards?

8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?

Print Name: Daniela Carusi

YES **NO**

9-A. Have you ever voluntarily relinquished any medical staff membership?

9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

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

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

12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?

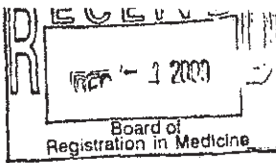
13. Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or third party programs?

14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?

15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?

15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature: Daniela Carusi **Date:** 11/11/00



POSTGRADUATE VERIFICATION

Commonwealth of Massachusetts--Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

RECEIVED DEC 22 2000 BOARD OF REGISTRATION IN MEDICINE

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Daniela Caru Date: 11/11/00

Print or Type Name: DANIELA CARUSI

Name of Institution: BRIGHAM & WOMEN'S HOSPITAL

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registration in Medicine at the address above. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training to the Board.

Name of Institution: Brigham and Women's Hospital-Massachusetts General Hospital Integrated Residency Training Program In Obstetrics and Gynecology

If name of Institution was different when applicant attended, please enter name: N/A

Enrollment and Participation: Our records indicate that Daniela Carusi, MD participated in the following program:
(type or print applicant's name)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, Internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	1	Ob/Gyn	6/20/97	6/30/98	Yes	ACGME
Residency	2	Ob/Gyn	7/1/98	6/30/99	Yes	ACGME
Residency	3	Ob/Gyn	7/1/99	6/30/00	Yes	ACGME
Residency	4	Ob/Gyn	7/1/00	Present / /	expected to on 6/22/01	ACGME
			/ /	/ /		

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Daniela Carusi

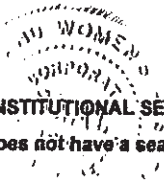
Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

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

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

COMMENTS: ____________

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



AFFIX INSTITUTIONAL SEAL HERE

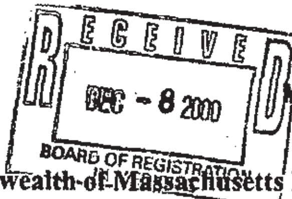
(If the institution does not have a seal, this form must be notarized)

Program Director's Signature: Robert Barbieri

Print Name: Robert L. Barbieri, MD

Academic Title: Chairman, Program Director, Dept of Ob/Gyn

Telephone: (617) 732-4265 Today's Date: 11/30/00



MEDICAL EDUCATION VERIFICATION

Commonwealth of Massachusetts Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

MEDICAL EDUCATION VERIFICATION

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

Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution to the ***Massachusetts Board of Registration in Medicine.***

Applicant's Signature: Daniela Carusi Date of Birth

Print or Type Name: CARUSI (Last name) DANIELA (First Name) A (Middle Initial) Social Security No:

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

Name of Medical School: UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

Address: Office of Student Affairs, 573 Parnassus Av, Room 5245 City: San Francisco State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

______

Premedical Education: Does your school have a premedical school education requirement? [X] Yes [ ] No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: University of California Los Angeles

Undergraduate School Address: Los Angeles, CA

Continued on back

MEDICAL EDUCATION VERIFICATION

Enrollment and Participation: Our records indicate that

Carusi — Daniela — A.
(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	09 / 07 / 92	06 /15 / 93	07 / 1 / 95	06 / 30/ 96
	09 / 01 / 93	06 / 30/ 94	07 / 1 / 96	06 /08 / 97 * Please see
	07/ 01/ 94	06/30/ 95	/ /	/ / attached sheet

The applicant attended 33-48 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one ☒ was awarded a degree in Medicine on (month/day/year) 06 / 08 /97

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

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

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

COMMENTS: ____________

AFFIX INSTITUTIONAL SEAL HERE
(If the institution does not have a seal, this form must be notarized)

INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Maxine Papadakis

Print Name: Maxine Papadakis, MD

Title: Associate Dean

Date: 12 /05 / 00 Telephone: (415) 476.1216

Thank you for completing this form.

Massachusetts Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

PART A

1) Current Status: Active **Renewal Due Date:** 06/25/2007 **Birth Date:**

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

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

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ *Check here to change this address*

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

RECEIVED
MAY 14 2007
Board of Registration in Medicine

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
Brigham & Women's Hospital
75 Francis St
Boston, MA 02115

Phone: (617)732-5452

☐ *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)232-6346

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: Daniela A Carusi, M.D. **License No.: 209257**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: ______

b) Federal (DEA): ______

c) Federal (DEA) XS: ______

Please make corrections as necessary

8) Other states where you are now licensed to practice

__ __ __ __ __ __ __

9) States where you were previously licensed

__ __ __ __ __ __ __

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Brigham & Women's Hospital	Boston	MA	☐
			☐
			☐
			☐
			☐

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

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

b) outpatient care 24 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 1/1/2007 To 12/31/2007

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

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

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

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

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

☐ A Government Employee under Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: ______

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

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

Massachusetts Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.: 209257**

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: Daniela A Carusi, M.D. **License No.: 209257**

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 6 3 9 1 3 6 0 9 6

☐ I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)

☐ I have applied for an NPI using a third party (enter name): ____________ (follow instructions for Option 3)

☐ By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.

☐ As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	Obstetrics & Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number: ☐☐☐ - ☐☐ - ☐☐☐☐

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

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

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

Signature: [signature] Date: 5 / 10 / 07

Massachusetts Physician Renewal Application

Physician Name: Daniela A Carusi **License No.:** 209257

PART A

1) Current Status: Active **Renewal Due Date:** 06/25/2005 **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.

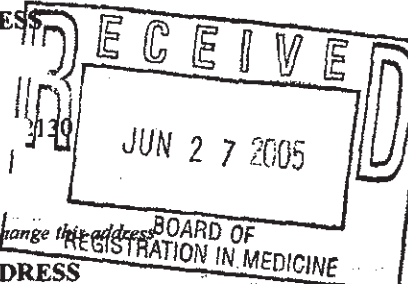
Please make corrections (print)

2a) MAILING ADDRESS

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

☒ *Check here to change this address*

2b) HOME ADDRESS



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

Phone:

☒ *Check here to change this address*

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Brigham & Women's Hospital
75 Francis St
Boston, MA 02115

Phone: (617)732-4840

☒ *Check here to change this address*

Business Address:
City/Town: State:
Zip: Country:
Business Telephone: (617) 732-5452

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 617-232-6346

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

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

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Correct?**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☒	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Daniela A Carusi **License No.: 209257**

(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: Hospital Change to: ____________________
Please enter the *approximate* number of work hours at your principal work setting: 70

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

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Brigham & Women's Hospital	☐	Admitting		70
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

11) Care of patients in Massachusetts *(See Renewal Instructions, page 4.)*
Average weekly hours involved in: a) inpatient care 24 hrs/wk Change to: _____ hrs/wk
b) outpatient care 24 hrs/wk Change to: _____ 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: Daniela A Carusi **License No.: 209257**

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

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

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

	YES	NO
14) CLAIMS MADE a) 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: Daniela A Carusi **License No.: 209257**

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.

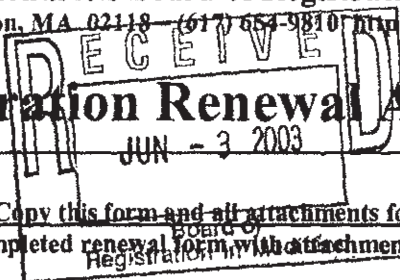
Under penalties of perjury, I declare that I have examined this renewal application and all its accompanying instructions, forms and statements, and to the best of my knowledge and belief, the information contained herein is true, correct, and complete. I authorize the Board of Registration in Medicine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

Signature: [signature] Date: 5 / 13 / 08

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

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.

- **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.: 209257   Renewal Date: 07/23/2003

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:
Daniela A Carusi

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: 75 Francis St
City/Town: Boston State: MA
Zip: 02115 Country: USA
Business Telephone: (617) 732-6092

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:
University of California School of Medicine, SF

b) Year Graduated: 1997   c) Degree: M.D.

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

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

0

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

8. Drug License Numbers, if
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: 921 / ✓ (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): ____

PRINT YOUR LAST NAME: Carusi LICENSE NUMBER: 209257

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) 1 0 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 24 hrs/wk B) outpatient care 24 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.

	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: Daniela Carusi Date: 5/30/03

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

Current Status: Active **License Expiration Date:** 7/23/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America
(617) 732-5452

3) **Email Address:**

4) **Fax Number:** (617) 232-6346

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

WorkSite	Location
Brigham & Women's Hospital	Boston, MA

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 20 hrs/wk
b) outpatient care 20 hrs/wk

12) Medical Liability Insurance Information

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

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

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

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

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

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

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

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

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

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

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

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

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

25) Electronic Health Records Proficiency
I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

Current Status: Active **License Expiration Date:** 7/23/2013

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America
(617) 732-5452

3) **Email Address:**

4) **Fax Number:** (617) 232-6346

5) **Specialties**
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

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

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

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

WorkSite	Location
Brigham & Women's Hospital	

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

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

12) Medical Liability Insurance Information

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

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

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

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

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

Current Status: Active **License Expiration Date:** 7/23/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America

Home Address:

Business Address:

Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America
(617) 732-5452

3) **Email Address:**

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

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WorkSite	Location
Brigham & Women's Hospital	
Faulkner Hospital	Jamaica Plain, MA

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

11) Care of patients in Massachusetts
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b) outpatient care 24 hrs/wk

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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, please answer Yes)** Yes

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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Daniela A Carusi, M.D. **License No.:** 209257

Current Status: Active **License Expiration Date:** 7/23/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Brigham & Women's Hospital
75 Francis St
Boston
Massachusetts - 02115
United States of America

Home Address:

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Daniela Carusi, M.D.

CURRICULUM VITAE

PERSONAL

HOME ADDRESS

WORK ADDRESS — Brigham and Women's Hospital
Department of Obstetrics and Gynecology
75 Francis St.
Boston, MA 02115

EMAIL

BIRTHPLACE — Mountain View, Califoı

EDUCATION

1997	University of California, San Francisco	M.D. with thesis
1992	University of California, Los Angeles	B.S., Psychobiology

AWARDS & HONORS

1997	American Medical Women's Association	Scholastic Achievement Award
1996	University of California, San Francisco	Alpha Omega Alpha
1992	University of California, Los Angeles	Summa Cum Laude
1992	Department of Psychology, UCLA	Highest Honors
1991	University of California, Los Angeles	Phi Beta Kappa
1987	University of California	Regents' Scholarship

CLINICAL EXPERIENCE AND EMPLOYMENT

1997-Present — Department of Ob/Gyn — Brigham & Women's Hospital, Massachusetts General Hospital

- As a resident physician I have had extensive patient care responsibilities in the inpatient setting, in a weekly continuity clinic, and as a consultant within the hospitals. I have taken responsibility for medical student education within the department, and for instructing more junior residents in their clinical duties.

1993-94 — Medical Scholar's Program — UCSF

- As a program instructor I prepared instructional materials and led weekly discussion groups in anatomy and physiology for freshman medical students.

1990-93 *Orientation Program* UCLA

- As an Orientation Counselor I organized and conducted workshops regarding study skills, time management, diversity issues, and pre-medical planning. I also provided academic and personal counseling for incoming students.

1990-92 College of Letters and Sciences UCLA

- As a tutor for the college, I instructed UCLA undergraduate and graduate students in English composition, grammar, and English as a second language.

RESEARCH EXPERIENCE

Present Department of Obstetrics Brigham & Women's Hospital

- With Dr. Aviva Lee-Parritz I am reviewing our institution's experience with different labor induction agents in terms of safety and effectiveness.

1995-97 Department of Obstetrics & Gynecology UCSF

- Under Dr. Lee Learman I designed and implemented a clinical study regarding knowledge of and attitudes towards HIV testing among antenatal patients.

1993 *Behavioral Neurology Program* UCLA

- Under Dr. Jeffrey Cummings I assisted in developing a psychiatric inventory for use on patients with dementia.

1991-92 Department of Psychology UCLA

- Under Dr. Eran Zaidel I conducted original research in cognitive neuropsychology.. I also implemented a computerized system for testing hemispheric specialization in human subjects.

PUBLICATIONS

Carusi D. Phytoestrogens as hormone replacement therapy: An evidence-based approach. *Primary Care Update for Ob/Gyns*, in press.

Carusi D, Learman LA, Posner SF. Human immunodeficiency virus test refusal in pregnancy: A challenge to voluntary testing. *Obstetrics & Gynecology*, 1998; 91(4):540-5.

Weekes NY, **Carusi D**, Zaidel E. Interhemispheric relations in hierarchical perception: A second look. *Neuropsychologia*, 1997; 35(1):37-44.

Cummings JL, Mega M, Gray K, Rosenberg-Thompson S, **Carusi DA**, Gornbein J. The Neuropsychiatric Inventory: Comprehensive assessment of psychopathology in dementia. *Neurology*, 1994; 44(12):2308-2314.

PROFESSIONAL AFFILIATIONS

1997 - 2000 Junior Fellow of the American College of Obstetrics & Gynecology

1998 - 2000 Member of the Massachusetts Medical Society

VOLUNTEER EXPERIENCE & ACTIVITIES

1993-97 Homeless Health Clinics UCSF

- I volunteered clinical services in the student-run clinic and instructed medical students in history taking and physical examination.

1993-94 Stand Up Against Homelessness UCSF

- With other medical students, initiated and coordinated large-scale fund-raiser for UCSF's Homeless Clinics.

1992-93 Med Teach Program UCSF

- With fellow medical students I developed an original science curriculum and taught students at Aptos Middle School weekly.