

RECEIVED

FEB 18 2011

REDACTED COPY

Application #: 246927  
Date of Issue: / /

Board of Registration  
in Medicine

Board of Registration in Medicine

200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880

Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

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

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

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

KIRTON DONALD EDWARD  
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

M.D.  D.O.  Ph.D  Other degree  Male  Female

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

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

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Month Day Year

WARWICK RHODE ISLAND  
Place of Birth: City State/Province/Territory Country if not USA

\*Mailing Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
City Street Zip (or postal) Code

Home Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
City Number and Street State/Province/Territory Zip (or postal) Code

Business Address: 759 CHESTNUT ST. Telephone: 413-794-5321  
Number and Street

SPRINGFIELD MA 01199  
City State/Province/Territory Zip (or postal) Code

E-mail Address: \_\_\_\_\_ Fax number: 413-79

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

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

CK # 1008  
02/23/11  
WS

51  
1 03/28/11

PRINT NAME: DONALD EDWARD KIRTON

**Pre-medical School**

Facility: BOSTON UNIVERSITY Degree: BA From 07/02/1999 To 05/18/03  
Street: 881 Commonwealth Ave City: BOSTON State: MA

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ / / \_\_\_\_\_ / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Medical School**

Facility: TUFTS UNIVERSITY School of MEDICINE Degree: MD From 08/25/03 To 4/20/07  
Street: 145 Harrison Ave City: BOSTON State: MA

Facility: \_\_\_\_\_ Degree: \_\_\_\_\_ / / \_\_\_\_\_ / /  
Street: \_\_\_\_\_ City: B State: \_\_\_\_\_

Date of medical school graduation: MAY / 20 / 2007  
Month Day Year

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

**Postgraduate Education:**

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

Facility: BAYSTATE MEDICAL CENTER Position: PGY 1 From 07/01/07 To 06/30/08  
Street: 759 CHESTNUT ST City: SPRINGFIELD State: MA

Facility: BAYSTATE Medical Center Position: PGY 2 From 07/01/08 To 06/30/09  
Street: 759 CHESTNUT ST City: SPRINGFIELD State: MA

Facility: BAYSTATE Medical Center Position: PGY 3 From 07/01/09 To 06/30/10  
Street: 759 CHESTNUT ST City: SPRINGFIELD State: MA

Facility: BAYSTATE Medical Center Position: PGY 4 From 07/01/10 To / / PRESENT  
Street: 759 CHESTNUT ST City: SPRINGFIELD State: MA

Facility: \_\_\_\_\_ Position: \_\_\_\_\_ / / \_\_\_\_\_ / /  
Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**Examination History**

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

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

<u>Examination</u>	<u>Most Recent Date taken (Month/Year)</u>	<u>Passed (P) or Failed (F)</u>		<u>Number of attempts</u>
USMLE Step I	06/05	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	1
USMLE Step II	06/07	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	2
USMLE Step III	06/09	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	1
NBME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Component 1		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Component 2		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Pre-1985		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 1		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 2		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 3		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMVEX		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Single		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
State Board Exam		<input type="checkbox"/> P	<input type="checkbox"/> F	
	(State of examination)			

03/20/11

PRINT NAME: DONALD EDWARD KIRTON

51  
4 03/28/11

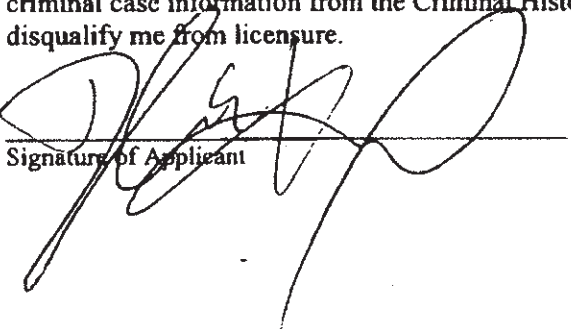
**Hospital Affiliations and Employment**

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

		<u>From</u>	<u>To</u>
Facility: <u>N/A</u>	Position: _____	_ / _ / _	_ / _ / _
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	_ / _ / _	_ / _ / _
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	_ / _ / _	_ / _ / _
Street: _____	City: _____	State: _____	
Facility: _____	Position: _____	_ / _ / _	_ / _ / _
Street: _____	City: _____	State: _____	

1. List other states (abbreviations) where you are currently or have ever had a full license: N/A
2. a) Are you certified by the American Board of Medical Specialties?      Yes      No  
     b) Are you certified by the American Board of Osteopathic Medicine?      Yes      No
3. List Board Certification(s): N/A      Certification date: \_ / \_ / \_  
     \_\_\_\_\_      Certification date: \_ / \_ / \_
4. List your practice specialt(ies) OB/GYN
5. Have you attached an up-to-date copy of your curriculum vitae?     Yes     No
6. Reason for requesting a Massachusetts medical license: to practice as  
     a generalist
7. Name of Facility: currently applying and interviewing  
     Address: \_\_\_\_\_      City: \_\_\_\_\_
8. Anticipated starting date in Massachusetts: 07/01/11

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

  
Signature of Applicant

02 / 16 / 11  
Month    Day    Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

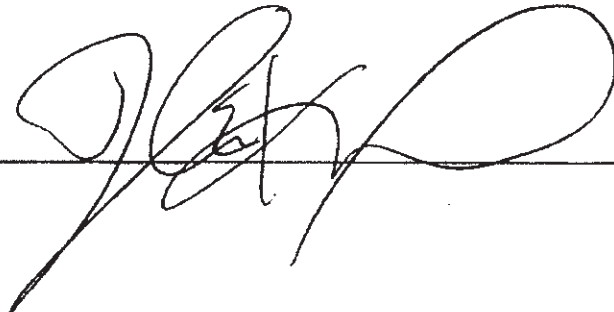
My current NPI is: 

1	5	3	8	3	6	8	8	7	3
---	---	---	---	---	---	---	---	---	---

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature:  Date: 02/16/11

# Donald E Kirton, MD

---

51  
3 03/28/11

## POSTGRADUATE TRAINING

Baystate Medical Center/Tufts University School of Medicine  
Obstetrics and Gynecology Residency Program  
Springfield, MA ~07/2007-present  
• Interview Committee

## EDUCATION

Tufts University School of Medicine  
Boston, MA ~08/2003-06/2007

Boston University  
Boston, MA ~09/1999-05/2003  
• B.S. in Biology, *Cum Laude*

## PUBLICATIONS

Dorer, M.S., Kirton, D., Bader, J.S., Isberg, R.R. "RNA Interference Analysis of *Legionella* in *Drosophila* Cells: Exploitation of Early Secretory Apparatus Dynamics." *PLoS Pathogens* 2 (4):e34 DOI:10.1371/journal.ppat.0020034 2006 April.

## RESEARCH

Research Assistant, Baystate Medical Center, Springfield ~2009 - Present  
Primary Investigator: Heather Sankey. Ongoing project incorporating a Boot Camp type training experience into the residency program at Baystate. Utilizing test scores, evaluations, and self-evaluation to determine the efficacy of the course as well as to make improvements in the training.

Research Assistant, Tufts-New England Medical Center, Boston ~2004 - 2005  
Supervisor: Ralph Isberg, Ph.D.  
Identified host genes in *Drosophila* fly species required for *L. pneumophila* intracellular growth using RNAi techniques in . Developed an automated computer-camera interface program for fluorescent image capturing and data analysis.

Lab Technician, Tufts - New England Medical Center, Boston ~2002 - 2003  
Supervisor: Larry G. Moss  
Maintained zebrafish facility and screened for multiple phenotypes and genotypes in mutant populations.

## AWARDS

Resident Teacher of the Year Award. Selected by Tufts University Medical School as a resident to be recognized for accomplished teaching in the Obstetrics and Gynecology clerkship at Baystate Medical Center 2007-2008

Howard Hughes Undergraduate Research Scholarship, Tufts University School of Medicine 2002

## LANGUAGES AND INTERESTS

Basic knowledge of Spanish  
Medical Education, Music, Sports, Home Repair, Landscaping.

RECEIVED  
FEB 23 2011  
Board of Registration  
in Medicine

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

**MEDICAL EDUCATION VERIFICATION**

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

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

Applicant's Signature: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Print or Type Name: KIRBTON DONALD E Social Security No: \_\_\_\_\_  
(Last Name) (First Name) (Middle Initial)

Other Name(s) KIRBTON DONALD E JR.  
(Please type or print name(s))

Name of Medical School: TUFTS UNIVERSITY SCHOOL OF MEDICINE

Address: 145 Harrison Ave. City: BOSTON State or Province: MA

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

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

**APPLICANT'S EDUCATIONAL HISTORY**

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

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

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

Applicant's Undergraduate School: BOSTON UNIVERSITY

Undergraduate School Address: BOSTON, MA

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that

(type or print the applicant's name) KIRTON DONALD E.  
(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
		<u>8/25/03</u>	<u>5/12/04</u>	<u>7/3/06</u>	<u>4/20/07</u>
		<u>8/16/04</u>	<u>5/13/05</u>	<u>1/1</u>	<u>1/1</u>
		<u>7/5/05</u>	<u>6/16/06</u>	<u>1/1</u>	<u>1/1</u>

The applicant attended 148 total weeks or \_\_\_\_\_ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one  was awarded a degree in MD on (month/day/year) 5/20/07  
 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: *Carol A. Duffey*  
Print Name: CAROL A. DUFFEY  
Title: REGISTRAR  
Date: 1/31/11 Telephone: (617) 636-6528

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



**MALPRACTICE HISTORY**

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

91  
18 03/28/11

**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. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the completed Malpractice History 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
5. dates of policy coverage must be included.

**Liability Carrier's Instructions:** If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. **IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.**

Liability Carrier: BAYSTATE HEALTH Insurance Company From: 07/07 To: 07/11  
City: Grand Cayman State: Grand Cayman Policy Number: 10110  
Islands

Liability Carrier: \_\_\_\_\_ From: 1 To: 1  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Liability Carrier: \_\_\_\_\_ From: 1 To: 1  
City: \_\_\_\_\_ State: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Applicant's signature: [Signature] Date: 02/16/11

Print Name: DONALD EDWARD KEATON

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip code: \_\_\_\_\_

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

**POSTGRADUATE TRAINING VERIFICATION**

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

Applicant's Signature: *[Signature]* Date: 01-21-2011  
 Print or Type Name: DONALD EDWARD KERTON  
 Name of Institution: BAYSTATE MEDICAL CENTER

**INSTRUCTIONS TO THE PROGRAM DIRECTOR**

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

Name of Institution: Baystate Medical Center  
 If name of institution was different when applicant attended, please enter name: \_\_\_\_\_

Enrollment and Participation: Our records indicate that Donald E. Kerton participated in the following program:  
 (Print applicant's name)

(List each year separately with from and to dates)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO		
Internship	PGY 1	OB/GYN	7/1/07	6/30/08	Yes	ACGME
Residency	PGY 2	"	7/1/08	6/30/09	Yes	"
Residency	PGY 3	"	7/1/09	6/30/10	Yes	"
Residency	PGY 7	"	7/1/10	6/30/11	NO	"

(Continued on page 2)

APPLICANT'S NAME: Donald G Kirtan

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

**QUESTIONS**

YES

NO

- 1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?
- 2. Was the applicant ever placed on probation?
- 3. Was the applicant ever disciplined or under investigation?
- 4. Were any negative reports ever filed by instructors regarding the applicant?
- 5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?
- 6. During the applicant's participation, our postgraduate medical training  was accredited by:  ACGME  Other: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

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

**AFFIX INSTITUTIONAL SEAL  
HERE**

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

*Raymond J. [Signature]*

Program Director's Signature: *Heather E [Signature]*  
 Print Name: Heather E Santy, MD  
 Academic Title: Program Director  
 Telephone: 413 794 5321 Today's Date: 1, 29, 11

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

SUPPLEMENT FORM

PRINT NAME: DONALD EDWARD KIRTON DATE: 02/16/11

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

QUESTIONS

YES NO

- 1. Since your enrollment in college, have you been subject to any disciplinary action...
2-A. Have you ever been terminated or granted a leave of absence...
2-B. Have you ever, for any reason, been placed on probation...
3. Have you ever applied for licensure or to sit for an examination...
4. Since your enrollment in college, have you been denied the privilege...
5. Have you ever failed any of the following examinations...
6-A. Have you ever, for any reason, been denied a medical license...
6-B. Have you ever voluntarily surrendered a license...
7. Have you ever, for any reason, lost American Board of Medical Specialty...
8-A. Are any formal disciplinary charges pending against you...
8-B. Has any disciplinary action ever been taken against you...

Applicant's Signature:

[Handwritten signature]

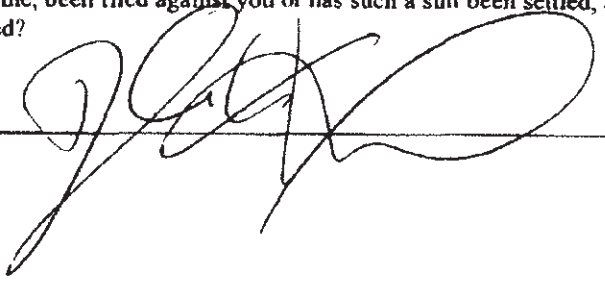
Date: 02/16/11

51 03-25-11

YES    NO

- 9-A. Have you ever voluntarily relinquished any medical staff membership?
- 9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
- 9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
- 9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
- 10. Have you ever been charged with any criminal offense, other than a minor traffic offense?
- 11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
- 12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?
- 13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?
- 14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?
- 15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
- 15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature: \_\_\_\_\_



Date: 02/16/11



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

**Physician Name:** Donald E Kirton, M.D.

**License No.:** 246927

**Current Status:** Active

**License Expiration Date:** 2/24/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:** 759 Chestnut St  
Springfield  
Massachusetts - 01199  
United States of America  
(413) 794-5321

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**  
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS
---------------	---------------	------------------

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

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

10) **Work Sites**

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

WorkSite	Location
Baystate Medical Center	Springfield, MA



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Donald E Kirton, M.D.

License No.: 246927

Wing Memorial Hospital

Palmer, MA

**11) Care of patients in Massachusetts**  
Average weekly hours involved in:

- a) inpatient care 30 hrs/wk  
b) outpatient care 20 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Health Insurance Co. Ltd.	07/01/2011	06/30/2012	Claims made with tail coverage

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

**14) Claims Made**

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

**15) Claims Closed**

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

**16) Other Civil Lawsuits**

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?  
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

**17) Criminal Charges**

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

**18) Other Issues**

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



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

**Physician Name:** Donald E Kirton, M.D.

**License No.:** 246927

---

- 21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?
- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes)





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

**Physician Name:** Donald E Kirton, M D

**License No.:** 246927

---

**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:** Donald E Kirton, M.D.

**License No.:** 246927

**Current Status:** Active

**License Expiration Date:** 2/24/2014

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:** 759 Chestnut St.  
Springfield  
Massachusetts - 01199  
United States of America  
(413) 794-5321

**3) Email Address:**

**4) Fax Number:**

**5) Specialties**  
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
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
Baystate Medical Center	Springfield, MA



Commonwealth of Massachusetts  
Board of Registration in Medicine  
Physician Renewal Application

Physician Name: Donald E Kirton, M.D.

License No.: 246927

Wing Memorial Hospital

Palmer, MA

**11) Care of patients in Massachusetts**  
Average weekly hours involved in:

- a) inpatient care 30 hrs/wk  
b) outpatient care 20 hrs/wk

**12) Medical Liability Insurance Information**

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Baystate Medical Center Self Insured	10/01/2013	10/01/2014	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?**



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

**Physician Name:** Donald E Kirton, M.D.

**License No.:** 246927

---

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



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

**Physician Name:** Donald E Kirton, M.D.

**License No.:** 246927

---

**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?**