

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

Refere proceedings	Phileacion
Before proceeding, please read the instruction booklet. • Copy this form and all attachments form	HEDACTED COP
• Copy this form and all attachments for your own records; you The Board will charge a fee for each copy.	will need copies for credentialing and other purposes.
· Remit \$250.00 for renewal fee.	/
· Add late fee of \$25.00, if necessary.	• Return renewal application in GREEN envelope.
	• Enclose check with coupon in BLUE envelope.
Registration No.: 26760 Renewal Date: 07/20	/07
1 Activity Status: The Activity Status	- 1000
Kettring	(see instructions) wish to renew
2. Other Name(s), if any, under which you were licensed.	
you were needsed:	Corrections (type or print)
	Other Name(s):
3. A) Mailing/Business Address:	
	Mailing Address: City/Town: State:
JOEL B BETTIGOLE, M.D.	City/Town: State:
3143 N 32ND ST	State:
PHOENIX, AZ 85018-6201	Zip: Country:
B) Home Address:	
nome Address:	Other Address: City/Town:
	Zip:Country:
Home Phone:	77
	Home: () Business: ()
Business Phone: (602) 533-0446	Dubinoss.
A) Date of Birth: C) Sex:	Date of Birth (M/D/Y):/_/ Sex (M/F):
B) Lic. Issue Date: D) CCH.	Lic. Issue Date (M/D/V).
09/21/61 D) 55#:	SS#:
B) Lic. Issue Date: 09/21/61 D) SS#: M A) Name of Medical School:	Full Name of Medical School:
A) Name of Medical School:	Full Name of Medical School:
A) Name of Medical School:	Full Name of Medical School:
A) Name of Medical School:	Full Name of Medical School:
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD	Full Name of Medical School:
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1)	Full Name of Medical School: Year Graduated: Degree (MD/DO):
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass.	Full Name of Medical School:
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A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certification	Full Name of Medical School: Year Graduated: Degree (MD/DO): Code(s)
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A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certificatio Code: OG Code: Drug License Numbers, if any:	Year Graduated: Degree (MD/DO): Code(s)
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certification Code: OG Code: Orug License Numbers, if any: A) Federal (DEA):	Full Name of Medical School: Year Graduated: Degree (MD/DO): Code(s)
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A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certificatio Code: OG Code: Drug License Numbers, if any: A) Federal (DEA): B) Massachusetts:	Year Graduated: Degree (MD/DO): Code(s)
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certification Code: OG Code: Drug License Numbers, if any: A) Federal (DEA): B) Massachusetts: A) Other states where you are now licensed to practice Abbr: Wy 25	Year Graduated: Degree (MD/DO): Code(s)
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certification Code: OG Code: Drug License Numbers, if any: A) Federal (DEA): B) Massachusetts: A) Other states where you are now licensed to practice Abbr: NV AZ B) States where you previously were licensed to practice	Year Graduated: Degree (MD/DO): Code(s)
A) Name of Medical School: Albany Medical College of Union University B) Year Graduated: 60 C) Degree: MD Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. GYN 0 Gynecology Current American Board of Medical Specialties Certification Code: OG Code: Drug License Numbers, if any: A) Federal (DEA): B) Massachusetts: A) Other states where you are now licensed to practice	Full Name of Medical School: Year Graduated: Degree (MD/DO): Code(s)

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

	PRINT NAME AND NUMBER: Last Name: Registration Number	Long
	Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Facility Code: / (AP)	Supply the codes from
	B. Additional health care facilities at which you previously held privileges or with which you were associated in the pa (See Table 3)	ast two (2) years.
	Facility Code: Facili	-
1	My medical malpractice insurance is covered by a)Insurance Carrierb) Letter of Credit	
	Name of Insurer:	
	Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice inst I am (check one) a) Not involved in direct/indirect patient care in Massachusetts b) Otherwise exempt Please explain exemption:	urance because
1	2. Are you currently in a nost-graduate training program in Many] Yes □ No
	3. A. What is your principal work setting? (See Table 4)	
	B. Care of patients in Massachusetts (see instruction booklet).	
	Average weekly hours involved in: a) outpatient carehrs/wk b) inpatient carehrs/wk	harb
	2) What is the approximate percentage of your patient care hours in primary care?%	WK
P	PART A	
-	uestions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question Form R for all YES answers except for question 22. Refer to the instruction booklet for additional	estion. Provide information and
I	THE PAST TWO (2) YEARS:	
		YES NO
	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?	
	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?	
	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?	
	Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	
	Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?	
20.	Have you withdrawn an application for a medical license or been denied a medical license for any reason?	
21.	Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?	
22.	Have you completed your CME requirements preceding your renewal date (see instruction booklet)?	
	☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption	
See	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.	
	RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANS	SWERED.
Sign	natureDate: /	1

JOEL First Name M	B liddle Initial		ETTIGOLE t Name	Suffi
Make changes to name here				
Mass License # 26760 License Status Inactive			First Issue Date	
3143 N. 32nd St. Phoenix, AZ 85018-6201 U.S.A. (602) 533-0446	Hospital	Affiliation		
Make address corrections here:	Make any corre	ctions to above he	re:	
Insurance Plan Affiliation:	Licenses Held in	Other States:	Accepting New Patier	its? □Yes □No
	NV AZ		Accept Medicaid?	☐Yes ☐ No
I. EDUCATION & TRAINING	(Please correct	as necessary)		
Albany Medical College of Union University Medical School	Degree	e	60 Date	
Make corrections here 805 (on On wrys 1 ty has Residency Program(s)	-lical G. for	7/62	6	64 End
Residency Program(s)	Start			End
Pesidency Program(s)	Start			End
. SPECIALTY	BOA	ARD CERTIFIC	CATION	
rimary Specialty: Gynecology			Board of Obstetrics	and Gynecology
condary Specialty:		fying Board Name		
ake any corrections here:	Make	e any corrections h	ere;	

	Nature	sachusetts Board of Registration in Medic	me.
		Date	Board Action
		*	
	- 0-		
V. HOSPITAL	DISCIPLINE		
	Hospital	Date	200
		- 1110	Disciplinary Action
	-0-		
1. CRIMINAL	CONVICTIONS		
The Board of I	Registration is unable to obtain as	curate data for this category at the present	time This inf
included when	the court system is fully compute	erized. Please list any criminal conviction	s. Include conviction date and not
or complaint	-0-	Fized. Please list any criminal conviction	morage conviction date and nature
II. MALPRACT	PIOE.		
	I B C B		
		N-	
Details of clain	ns paid for Dr. BETTIGOLE	No. of	Years in Practice: #
Details of clain Date	ns paid for Dr. BETTIGOLE		Years in Practice: #
Details of clain Date Date	Amount Paid 0.0000	Basis for Complaint	Years in Practice: #
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Board of Registration in Medicine

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111 1995-1997 Physician Registration Renewal Application

District the second sec	
Registration No. Status Fee Renewal Date Late F 26760 INACTIVE \$250.00 07/20/95 \$25. Mailing Address: JOEL B BETTIGOLE, M.D. 3143 NORTH 32ND STREET PHOENIX, AZ 85018	Correction of Mailing Address Address (Mailing): City/Town:
03010	
	Country:
Direction	
Directions: Before proceeding, please read the instruction booklet. Some	questions are optional
 Fallure to renew in a timely manner will cause your license to lapse ability to practice medicine in the Commonwealth. (See enclosed letter 	and may affect your
· Add late fee if necessary.	31(R)
 Make a copy of this form and all attachments for your own records - credentialing and other purposes. The Board will charge a fee for each copy 	you will need copies for py it provides.
 See instructions on detachable coupon at bottom of this page. 	
Pre-Printed Information	ROPPONENTARIA
	BOARD OF HEGISTRATION Corrections of Pre-Prints (United Prints P
 Other name(s), if any, under which you were licensed: 	
2. Home Address:	Name:Address:
	Country: Zip:
3. Date of Birth:	
Lie Jame Desert	Date of Birth (M/D/Y): Lic, Issue Date (M/D/Y): Sex (M/F):
Lie. Issue Date: // SS#:	Lic. Issue Date (M/D/Y):/ SS#:
Home Phone Rusiness Phone	77
Business Phone (602) 533-0446	Dustitess; ()
4. Name of Medical School:	Full Name of Medical School:
Albany Medical College of Union	
OHIVEEBICY	V
Year Graduated: 60 Degree: MD	Year Graduated: Degree (MD/DO):
5. a) Other states where you are now licensed to practice (Abbr):	AZ
of diaces wildle you previously were licemend to many	
**	CA IL TX WX
6. Specialty Code(s) (See Table 1);	Code Hours per Week in Mass.
Code Hours per Week in Mass.	
GYN 0 Gynecology	YAO
2	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (See	The same of the sa
	1
	Code:
8. Drug license number(s), if any: a) Federal (DEA)	
b) Massachusetts	Federal (DEA):
9. Activity Status: Lamon-Lite	Mass:
Activity Status: I am applying to be registered with the following status: I hereby certify that if requesting Y	ACTIVE INACTIVE
 I hereby certify that if requesting Inactive status, I will not practice me 	edicine, including writing process at
	writing prescriptions, in Massachusetts.

PRINT NAME AND NUMBER: Physician Last Name: Bettigole Registration Number:	2676	
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. See from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP)	Supply the	<u>C'</u>
racility Code: /(AP) Facility Code: /(AP) Facility Code:	(AP)	
Facility Code: /(AP) Facility Code: /(AP) Facility Code: /		
If 999, print name(s):	(VI.)	
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associate (See Table 3)	d in the past 2 y	ears.
Facility Code: Fa	~ ·	
If 999, write name(s): AVIZONE, ONLY -Good Somewiten Melong/Conter	/ Code:	
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, of List Insurer: Security Trust LIN (b)	check one.	
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance to (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: (ii) Otherwise exempt:	ecause I am	
12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes No (0	The also A	
13. a) What is your principal work setting? (See Table 4)	neck one)	
b) Care of patients in Massachusetts (See instruction booklet.)		
i) How many hours per typical week are you currently involved in outnotient care in Mass?		
ii) Flow many nours per typical week are you currently involved in innation care in Man?		
c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)		
Questions 14 through 24 refer to the past two years only. Check either VES or NO (NOT N/A)	letails on	
Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions. IN THE PAST TWO YEARS:		
	YES N	0
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
10. The day lawfull, built than a medical mainrachee suit which is related to your name of the		
resolved? the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
governmental authority, health care facility, group practice or professional society or association?		
or restricted by any state or federal agency?		
you will all application for a medical license or been denied a medical license for any reason?		
21. Has any professional hability insurance provider restricted limited terminated as in the state of the sta		
liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your abilities.		
2 That of your voluntarity informed by otherwise limited vour scope of practice of medicine for		
25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested No, training program exemption (see instruction booklet).		
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license we renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.	vill be	
• Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reason		
I ut sualit to U.L. C. O. C. Sec. 49A. I hereby cortify under the main and the second		
even if you reside out-of-state or out of the United States.	ils applies	,
 Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as r G.L. c. 119, sec. 51A. 		
• I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true. Signature:		
Signature: Date: 7/1/	25	

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

Registration No. Status Fee Renewal Date Late 26700 INACTIVE \$250.00 07/20/93 \$25.	
Malling Address: JOEL & BETTIGOLE, M.D.	Address (Mailing): 3143 M. 32nd 57 City/Town: Phase X State: A7 85018 Country Code (See Table 1):
 Directions: Staple check to bottom of form. Add late fee if necessare Questions 1-8 include information from Board files. Please correct as provided on the right hand side of the page. Before proceeding, please read the instruction booklet. Some questions Make a copy of this form and all attachments for your own record for credentialing and other purposes. The Board will charge a fee for Enclose the \$250.00 renewal fee by means of a certified check, money payable to the Commonwealth of Massachusetts. 	necessary in the boxes M.R. JUL 1 5 1993 s are optional. s - you will need copies each convit require. Pr. JUL 1 5 1993
Pre-Printed Information	Corrections of Pre-Printed Information
 Other name(s), if any, under which you were licensed: a) Address (Home): 	Name: Address (Home): City/Town:
b) Address (Business): 9100 N. 2ND STREET PHOENIX, AZ 85020	Country Code: If 999 print Country: Address (Business): 3143 N. 38 not 57 City/Town: Phase & A2 55 VI 8 Country Code: If 999 print Country:
Date of Birth: Lic. Issue Date: / B2 SS#: Telephone Number: Home Business (502) 997-7493 Name of Medical School: Albany Medical College of Union University	Date of Birth (M/D/Y): / Sex (M/F): Lic. Issue Date (M/D/Y): / SS#: Telephone Number: Home: OBusiness: GON 533 - OG Full Name of Medical School:
Year Graduated: 60 Degree: MD a) Other states where you are now licensed to practice (Abbr): CA	Year Graduated: Degree (MD/DO):
b) States where you previously were licensed to practice (Abbr): CT Specialty Code(s) (See Table 2): Code Hours per Week in Mass. GYN O Gynecology	Code Hours per Week in Mass. If OS, print specialty:
a) If you are currently American Specialty Board Certified, enter Codes: Code: Code:	Code;Code;
b) If you previously were American Specialty Board certified, but are not please enter codes of prior certification: (See Table 3) Code: Code: Drug License Number(s), if any: a) Federal (DEA) b) State (MA)	Code: Code:
I have completed my CME requirements in the two years preceding my r You must fill out a separate Waiver Form. The waiver must be granted b CME requirements. Do not submit documentation of your CMEs with your	the Roard before your license will be seened to

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: 18eth 80 fe Registration Number: 26 760
10. Activity Status: I am applying to be registered with the following status: Active Inactive
I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.
11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER or (b) LETTER OF CREDIT If applicable, check one
List Insurer:
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice incurance because I am
(Check One): (1) NOT IN VOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS: (ii) OTHERWISE EXEMPT:
12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code:
Facility Code: /(AP)
If 999, print name(s): (AP)
Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. [See Table 4.] Facility Code: Facili
If 999, write name(s):
13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes No (Check one)
14. a) What is your principal work setting? (See Table 5)
b) Care of patients in Massachusetts (MA) (See instruction booklet.) i) How many hours per typical week are you currently involved in outpatient care in MA? hrs/wk in MA hrs/wk in MA
Questions 15 through 23 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. Refer to the instruction booklet for additional information.
IN THE PAST TWO YEARS:
15. Has any medical malpractice claim been made against you reliable to the same made against you reliable to the same made against you reliable to the same made against your
15. Has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
17. Have you formally been charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
18. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
22. Are you now, or have you been in the past two years, dependent upon alcohol or drugs?
23. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage?
· Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.
 Pursuant to G.L. c. 62C, sec. 49A, I hereby certify under the penalties of perjury that, to the best of my knowledge and belief, I have filled all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the country.
· I hereby certify that I will fulfill my obligation to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A.
· I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.
Signature: Date: 7/0/93
Date: Zi-II



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

1571-1575 I Hysicia	an Registration Renewal Application
Registration No. Status Fee Renewal Date	E. B. B. B. L. L.
20760 INACTIVE \$150 07/20/91	For Office Use Only M.B
Pr. JOEL B BETTIGOLE -	PENTERED OCT 2 - 1991
-	Bk
	Ch/_/
Directions:	D.E
Questions 1-7 Include information from Board files. Please correct It as	
• before proceeding, please read the instruction booklet	**
Answer all non-ontional questions completely (7)	which questions are optional.)
Make a copy of this form and all attachments for your own records and all attachments are all attachments are all attachments and all attachments are all attachments and all attachments are all attachments are all attachments and all attachments are all attachments and all attachments are all attachm	sive health care facilities copies for credentialing purposes. The Board charges
Enclose the \$150.00 renewal fee by means of a certificity lack money of	which questions are optional.) The Board charges or credentialing purposes. The Board charges order or personal check made payable to the Commonwealth of Massachusetts.
Activity Status:	which of presonal check made payable to the Commonwealth of Massachusetts.
I am applying to be registered with the following status Active Lateral Acti	actice medicine in Massachusetts.
19.	Corlections of Pre-Printed Information
1. Other Name(s), if any, under which you were licensed.	Nage 1
Pre-Printed Information 1. Other Name(s), if any, under which you were licensed:	3.L.
2. a) Address (Home):	Address:
	City/Town_
	State: Zip:
2. b) Address (Business):	Country Code: (If 999 write Country):
1002 5 MC DOWELL ROAD	Address:
SULTE	City/Town:
PHJENIX . AZ 35006-	Country Code: (if 999, write Country):
·	
3. Date of Birth: Sex: N	Date of Birth (M/D/Y):/ Sex (M/F):
Telephone Number:	Lic. Issue Date(M/D/Y):/
Home Business	Home:
() - (602) 957~8535.	Business: (DOA) 777799
4. Medical School CodeN Y 0 0 3 Year Graduated 0 Degree: MD	School Code: Year Graduated: Degree (MD/DO):
Name of School:	16 00000
Albany Medical College of Union Univ 5. a) Other States where you are now licensed to practice (Abbn). A NY	t bily
b) States where you previously were licensed to practice (Abbr). T	Name and the same
, which includes to placeto (Abbit 1	_ 1
6. Specialty Code(s) (See Table 3):	
Code Hours per Week in Mass.	Code Hours per Week in Mass.
0 Obstetrics and Gynecol	ogy GYN O
O .	
	If OS, write specialty:
7.a) Are you American Specialty Board Certified? (Y/N)Y 7.b) If YES.	Enter Codes:
Code: OG Board of Obstetrics and Gy	ynecology Code:
Code:	Code:
9 December 1	
8. Drug License Number(s) (if any) [optional]: a) Federal (DEA)	b) How many DEA nos. do you have?
c) State (MA) #M	
9. I have completed my C.M.E. requirements in the two years preceding my	renewal date: YES Waiver Requested
requirements. Do not submit documentation of your CME's with your ren	William Hoord hotoro your linears will be well to
30M - 9/90 - P813971	For Office Use Only: Waiver Granted

[For Office Use Only: Waiver Granted_____ Date:___/

Physician Last Name: Betti Scle Registration No.: 26760
10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER or (b) LETTER OF CREDIT If applicable, check one.
List insurer: F (2A (TAII)
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check one (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: (ii) OTHERWISE EXEMPT:
(State how otherwise exampt):
11. Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 998/ (AP) Facility Code:/(AP) Facility Code:/(AP)
Facility Code:/_(AP) Facility Code:/_(AP) Facility Code:/_(AP)
If 999, write Name(s):
Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years.
Facility Code: Facili
W 000 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)
a) Are you currently in a post-graduate training program in MA as a resident or clinical follows. Yes
b) If you are in a MA program, are you a i) Resident ii) Clinical Fellow or [ii) Research Fellow? (Check one.) c) How many hours per typical week do you spend in this MA post-graduate training program?hrs./wk. In MA.
13. Care of Patients in Massachusetts (MA) (See instruction booklet.)
a) How many hours per typical week are you currently involved in <i>outpatient</i> care in MA?hrs./wk. in MA.
b) How many hours per typical week are you currently involved in inpatient care in MA? hrs./wk. in MA.
14. Principal Work Setting. a) What is your principal work setting? (See Table 6) 25
Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A.
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
The state of the s
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations, See feature).
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulationsSee Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?
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Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111

		1989-19	991 Physicia	an Registration	Berewii A	bilication.	Page 1 of 2	U	14892
Board Use Only:				11/1	De	571	-		
Registration No.	Status	Fee	Renewal Da	1/2	1 400000	-	\ <u>\</u>		
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form can result in	disciplinary ac	ction.	naroty bololo of	simpletting tries tottii.	Do not delega	не ина ипропа	it task to an el	npioyee, as ta	ise statements c
. Print legibly or type		5000.00000							
. Answer all non-opt	ional question	s (front and b	ack of form) co	mpletely-It is not ac	dequate to sta	te that the Bo	ard already h	es the Inform	etlon
. Sign the renewal ap	oprication at th	ne bottom of p	age one and fil	I in the number of at	tached nages I	n the nameneo	h shows the el	rn atrino	
. Make a copy of this	form and all	attachments fo	or your own rec	ords-vou must aive	hospitals and a	other health ca	re feellittee co	niae for anadan	tialing purposes
. Enclose the \$150 n	enewal fee by	means of a ce	ertified check, r	noney order or perso	onal check mad	de payable to ti	e Commonwe	alth of Massac	chusetts.
	-1	-				T /			
1. a) Name (LAST:)_					,(FIRST:)	DOR			,(M.).:)/
1. b) Other Name(s)	, if any, that yo	ou were ever l	icensed under:						
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2. d) Telephone (Bus	iness): 602	11957	- 05 75	Extension	2 a) Teleph	one (Home) (O	ntionally (1	
3. Date of Birth (MO)	/DA (VD).		A ACOUT.		z. oj reiopin	Oli (Billori) GO	phonaly.		
			4. 86)	C MALE L FEMALE	E	5. Social Secu	rity No. (Optio	nal):	
s. a) Medical School	Code (See Ta	ble 1): NY	20 7 199	999, write Name:					
i. b) Year Graduated	1960	6.0)[Degree: M.D.	/ 00					9.
ed) Country 110	2	0.070	ogico, w.b.p	_ b.o					
o. d) Country: U.S.	_ Canada_	_ Code if Of	ther (See Table	2): If 999	, write Name:_				
. Work Setting (Circ.									
10 Hospital	- arra marcata	0/			1		to and tests		
25 Clinic	_	%	15 Privat		100 %		artnership/Gro	up Practice	9
40 HMO Facilit	_			al Health Center	%		ursing Home		9
		%		ational Institution	%	50 M	edical Society		94
55 Governmen	I Facility	%	60 Plant	Commercial Setting	9%	99 O	ther		9
. Professional Activi	ty (Circle and	indicate Perce	ant/9/) of Profes	noinnal Times					
10 Resident or		%				WELL THE STATE OF		8. b) Mass. Li	
30 Administrati		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		ctice Involving Direct	Patient Care	100%		(see your wall	(certificate)
50 Medical Res				dical Teaching		%		(MO/DA/YR)	
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. Specialty Code (S	se Table 3): 0	BG- Percer	nt of Practice T	ime:/00 % Sp	ecialty Code:	Perce	nt of Prentice	Time: D	
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0. a) Are you Americ	en Specialty I	Board Cartifia	Y MAN CH	10. b) If YES, circle	L D	N-00			
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Al Board	of Allergy & Im	imunology	NM	Board of Nuclear N	fedicine	PS	Board of BI	astic Surgery	
A Board	of Anesthesiol	ogy	(OG)	Board of Obstetrice				eventive Medic	cine
	of Colon & Red		OP	Board of Ophthalm	ology	PN		yohlatry & Nei	
	of Dermatolog		OS	Board of Orthoped	ic Surgery	R	Board of Re		arology
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	of Family Prac		PA	Board of Pathology		TS		oracic Surgen	,
	of Internal Med		PE	Board of Pediatrics		U	Board of Ur	ology	
	of Neurologica		PMR	Board of Physical N	Aedicine & Ret	nabilitation			
 a) Hospitals at wh 	Ich you have	currently effect	tive privileges	and other Health Ca	re Facilities wit	th which you a	a associated	Percent of Pro	otice Time at an
(See Table 4.)	~- 4					,	- describing,	, orderit or , ia	Cilco Tittle at 60
(See Table 4.) Facility Code: _ Facility Code: _	997 1	2 %	Facility	Code:	%		Facility Code:		%
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If 900 write Non	na/a).	-1 50	~	m Ph		1-	•		
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I. b) Additional Hosp	itals at which	you previous!	v held privilege	es and other Health	Care Facilities	with which you	were associa	led in the neet	10 years
(See able 4.)								lod III lilo pasi	TO yours.
Facility Code: 7	99_	Facility	Code:	_ Facility Code:		Facility Code:		Facility Code:	
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	Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2	
		6760
Fill is	in name and number. Physician Last Name: 527/56/2. Registration No	
	a) Other States where you are now licensed to practice (Abbreviate): A LY TX # AZ	
12. b	b) States where you previously were licensed to practice (Abbreviate):	
	am applying to be registered with the following status: ACTIVE*INACTIVE If ACTIVE, answer questions 14. a) the first state of the fi	nrough c). only.
14. a	a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: (Fill in # of hours or type of residency, or che Category I:	eck waiver.)
14. b	b) My medical malpractice insurance is covered by INSURANCE CARRIER LETTER OF CREDIT If applicable, check one and identify the Insurer: If applicable, check one and identify the Insurer: Institution Issuing Letter of Credit: Alternatively, Indicate as follows: 1 am registering with ACTIVE status, but 1 am not covered by medical malpractice insurance because 1 am (CI NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE OTHERWISE EXEMPTED (State how)	
	c) Percent of Practice Time in Massachusetts:%	
Que	stions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.	es No
15. l	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?	
16. 1	Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	
17.	Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations-See Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?	
	If you answered 'YES' to question 15, 16, or 17 provide details on Form 15A, attached.	
****	电影对电影表示,我们是一个人,	****
Que	estions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.	
	dions to through a trivial to the partition of the partit	es No
18.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?	es No
18.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason?	es No
19. I	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	es No
19. I	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason?	es No
19. I 20. I 21. I 22.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine? Are you now, or have you been in the past, dependent upon alcohol or drugs?	es <u>No</u>
19. I 20. I 21. I 22.	Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine? Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	<u>No</u>

€ ¥

DIVISION OF REGISTRATION ROOM 1520 — 100 CAMBRIDGE STREET BOSTON, MASSACHUSETTS 02202 RENEWAL APPLICATION BOARD OF REGISTRATION IN MEDICINE

> AS A REGISTERED PHYSICIAN

> > REGISTRATION NO

26760

IMPORTANT - READ, COMPLETE AND SIGN --PURSUANT TO M.G.L. C.62C, S.49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO OR FEDERAL IO NO 11 .

PAY THIS

AMOUNT

XOU MUST SIGN BELOW

APPLICANT'S SIGNATURE DATE TO BE RENEWED FEE LATE FEE MO DA YR 100.00 15 100.00 01 84

COMPLETION OF CONTINUING EDUCATION REQUIREMENTS IN COMPLIANCE WITH THE BOARD'S STATUTES AND/OR RULES AND REGULATIONS.

PLEASE USE THE ENCLOSED RETURN ENVELOPE

MY SIGNATURE ON THIS RENEWAL '

APPLICATION INDICATES THAT I ATTEST UNDER THE PAINS AND

PENALTIES OF PERJURY TO THE

THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A CERTIFIED CHECK OR MONEY ORDER — PAYABLE TO:

COMM. OF MASS. P.O. BOX 6 BOSTON, MASS. 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

3500600267609 011584 10000000009

DO NOT FOLD OR STAPLE THIS FORM

CODE

MD

TYPE

JOEL B BETTIGOLE

LICENSE NUMBER

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW UU NOT WRITE BELOW THIS LINE

	Principal Specialty(rest: * 3 0 2 2 Principal work setting: * 4 0
	3. Home Address: 925 E. m. Daniell Normall Az 85010 5. States other than Massachusetts in which you are licensed to practice: AZ
	6. Has a judgement been returned against you or a malpractice suit since 1/15/82?
	7. Have you ever been convicted of any criminal offense other than minor traffic offenses?
	8. Has any disciplinary action been taken against you in this state or any other?
-	9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any office? ———————————————————————————————————
	10. I have completed my C.M.F. requirements between 1/15/82 & 1/15/84 as follows:*
	THEREBY CERTIFY UNDER THE PENALTY OF PERCURY THAT FOR ABOVE INFORMATION IS TRUE.
	* SET GODE SHELL

3OARD OF REGISTRATION IN MEDICINE

ROOM 1507 - 100 CAMBRIDGE STREET BOSTON, MASSACHUSETTS 02202 RENEWAL APPLICATION 1986-1988

IMPORTANT - READ, COMPLETE AND SIGN -

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO. OPTIONAL

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.) I IF YOU ANSWERED "YES" TO ANY OF THESE QUES-TIONS, YOU MUST CHECK THIS BOX:

YOU MUST SIGN BELOW

PLEASE USE THE ENCLOSED RETURN ENVELOPE

SEE REVERSE SIDE

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

PAYABLE TO:

COMMONWEALTH OF MASSACHUSETTS

P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

PAY THIS AMOUNT DATE TO BE RENEWED FEE LATE FEE REGISTRATION NO MO DA YR 26760 100.00 100.00 01 15 86

JOEL B BETTIGOLE

LICENSE NUMBER

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

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DO NOT FOLD OR STAPLE THIS FORM

CODE

MD

TYPE

Print Name. Toel B. Bettigde, mp_ Date of Birth.	
Medical School: A locky medical College Date of Graduation: 6/1/60 You must read the instructions enclosed with this form to answer questions 1-12	
1. Principal Specialty(ies): Admini 5 tration, Of-GYN 2. Principal work setting 4 mo	
3. Home address Same as Pront 4. Principal business address. Po Box 20	25-75
Dallas IX	25770
5. List all hospitals at which you have currently effective privileges 20008 CCONA AL	altholay
6. States other than Massachusetts in which you are licensed to practice. Arizona	
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?	YES NO
Have you been a detendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?	
Plas any disciplinary action been taken against you in the last len years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	
 9. Has any disciplinary action been taken against you in the last lon years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)? 10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other? 	
professional medical association (international, national, state or local)?	30) at 422)

POARD OF REGISTRATION IN MEDICINE

TEN WEST STREET **BOSTON, MASSACHUSETTS 02111** RENEWAL APPLICATION 1987-1989

REGISTRATION NO.

26760

LICENSE NUMBER

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CODE

MD

SOC. SEC. NUMBER, OPTIONAL	-	ا ا	1 14		
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JOEL B BETTIGOLE

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: PPLEASE USE THE ENCLOSED RETURN ENVELOPE

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

PAYABLE TO: COMMONWEALTH OF **MASSACHUSETTS**

TEN WEST STREET, 2nd FLOOR BOSTON, MASSACHUSETTS 02111

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

VOLUMENT DEAD THE INSTRUCTIONS SHOULDSED WITH THE FORM TO A		
1. Print Name: TORI B. BETTI 9 of		
All mand office -	2. Date of Birth; MONTH	DAY
1154	To leave	
Country where Medical School located:	5. Date of Graduation: UCne 1960	
6. American Specialty Board Certified? X (Check if yes.) Which Boards?		
7. Principal Specialty(les): OB-CYN	8. Principal work setting: HMO	
9. Home address: 5ame as above	100 - 0 -	a , Min
s. Home aduless.	10. Principal business address: 4775	230-
G+ Q	1.400 / 1200	
11. List all hospitals at which you have currently effective privileges: 57. 100		7×
12. List all hospitals at which you have held privileges in the past 20 years: 🚉	y Hote medical Center 5 ptd, MA Janovitant	togos Phoenix
States other than Massachusetts in which you are presently licensed to pract	ctice: AZ, /X	
14. List any other states where you were previously licensed to practice:	<u>-T</u>	
		YES NO
15. Has any medical malpractice claim been made against you in the last ten ye	ears (whether or not a lawsuit was filed in relation to the claim)?	
16. Have you, at any time, been a defendant in any criminal proceeding other th	nan minor traffic offenses?	
 Are any formal disciplinary charges pending or has any disciplinary action t authority, by any hospital or health care facility, or by any professional med 	ilical association (international national state or local)?	
18. Has your privilege to possess, dispense or prescribe controlled substances or have you been called before or warned by this state or any other jurisdict	ever been suspended, revoked, denied, restricted, surrendered, tion including a federal agency, at any time?	-
19. Have you ever withdrawn an application for medical licensure or been denie	ad a medical license for any reason?	
20. Have you ever had any mental illness which has impaired your ability to prac	ctice medicine or to function as a student of medicine?	٦
21. Have you ever had an organic illness which has impaired your ability to prac	ctice medicine or to function as a student of medicine?	
22. Are you now, or have you been in the past, dependent upon alcohol or drug		1
23. Have you ever, for any reason, lost American Specialty Board Certification?		. –
24. Have you been denied recertification by one or more specialty boards?		
If yes, which one(s)? 25. I have completed my C.M.E. requirements in the two years ending on the rer	newal date as follows: Cest. T 116 Cat II 24	
	newal date as follows:	
26. I am an active Inactive practitioner. (Check One.)		
HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMAT PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO ABLE CHARGE FOR MY SERVICES.	TON ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEET O OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEI	'S IS TRUE. DICARE REASON-
PURSUANT TO M.G.L. c. 82C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NO		
	Ha examelo	
	SIGNATURE	
	DATE: 5/19/87	
(8	See Reverse Side)	

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111 1995-1997 Physician Registration Renewal Application

Registration No. Status Fee Renewal Date Late Fee 26760 INACTIVE \$250.00 07/20/95 \$25.00 Malling Address: ACCUSE BETTIGOLE, N.D. 3143 NORTH 32ND STREET PHOENIX, AZ 85018	
Directions: Before proceeding, please read the instruction booklet. Some	questions are optional.
 Failure to renew in a timely manner will cause your license to lapse a ability to practice medicine in the Commonwealth. (See enclosed letter Add late fee if necessary. 	M.R.
 Make a copy of this form and all attachments for your own records-credentialing and other purposes. The Board will charge a fee for each cop See instructions on detachable coupon at bottom of this page. 	y it provides.
Pre-Printed Information	Corrections of Pre-Prints Distriction
 Other name(s), if any, under which you were licensed: Home Address: 	Name:
3. Date of Birth: Sex: M Lic, Issue Date: / SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Lic, Issue Date (M/D/Y):/ SS#:
Home Phone Business Phone (602) 533-0446 4. Name of Medical School:	Home: Business: () Full Name of Medical School:
Albany Medical College of Union University Year Graduated: 60 Degree: MD	Year Graduated: Degree (MD/DO):
5. a) Other states where you are now licensed to practice (Abbr): NV b) States where you previously were licensed to practice (Abbr): CT	CA IL TX WX
6. Specialty Code(s) (See Table 1): Code Hours per Week in Mass. GYN 0 Gynecology	Code Hours per Week in Mass. If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (S	ee Table 2)
Code: OG Code:	Code:Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts	Federal (DEA): Mass:
9. Activity Status: I am applying to be registered with the following statu	IS: ACTIVE INACTIVE

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

PRINT NAME AND NUMBER: Physician Last Name: Bettigole Registration Number: 26760.
V
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code: /(AP) Facility Code: /(AP)
Facility Code: /(AP)
If 999, print name(s):
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3) Facility Code:
If 999, write name(s): AVIZENCE CHLY -Good Somewiten Melecal Conder
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, check one. List Insurer: Security Trust List List Insurer: List Insurer: Security Trust List Insurer: List Insurer: Security Trust List Insurer: List Insurer: Security Trust List Insurer: List Insurer: List Insurer: Security Trust List Insurer: List Insure
(Check One): (i) Not involved in direct/indirect patient care in Massachusetts:
12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes No (Check one)
13. a) What is your principal work setting? (See Table 4)
b) Care of patients in Massachusetts (See instruction booklet.) i) How many hours per typical week are you currently involved in outpatient care in Mass? ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.
IN THE PAST TWO YEARS: YES NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?
17. Have you been charged with any criminal offense, other than a minor traffic violation?
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?
25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested No, training program exemption (see instruction booklet)
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.
 Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.
 Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States. Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by
 G.L. c. 119, sec. 51A. I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.
Signature: Date: 716185

BOARD OF REGISTRATION IN MEDICINE ROOM 1507 - 100 CAMBRIDGE STREET BOSTON, MASSACHUSETTS 02202 RENEWAL APPLICATION 1986-1988

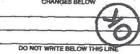
IMPORTANT - READ, COMPLETE AND SIGN -

YOU MUST SIGN BELOW

LICENSE NUMBER		PAY THIS	FEE	-DATE TO BE RENEWED			LATE FEE	
COOR	TYPE	REGISTRATION NO.	AMOUNT	1 1	MO	DA	YR	CATETILE
MB		26760	100.00	100.00	01	15	86	

JOEL B BETTICOLE

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW



SEE REVERSE SIDE

PURSUANT TO M.G.L. C. &C. & SASA, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BEJEF, HAVE FILED ALL STATE TAXES REQUIRED UNDER LAW.

STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. " IF YOU ANSWERED "YES" TO ANY OF THESE QUES-TIONS, YOU MUST CHECK THIS BOX:

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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



PAYABLE TO: COMMONWEALTH OF MASSACHUSETTS P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

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dical School:	and made of a	16-0	Date of Birth:	V. W. 1 May 21999		20
must read the instruction	ns enclosed with this form to answer	questions 1-12	ion:	1160		
Principal Specialty(ies):	Alministration	OB-GYN	2. Principal work setting	Hmo	· · · · · · · · · · · · · · · · · · ·	
Home address: 50m	eas front		4. Principal business ad	orem PoBo	2000	
8886-284	1636 618 508	<u> </u>		03/6		
List all hospitals at which	you have currently effective privileg	es none	a comment and the profession of the pro-	Claras		7/ 16 F
States other than Mass	achusetts in which you are license	ed to practice: Aviz	cona			
		1 - 1 1 J. W. J. T.		The state of		CUAD V
	ant in any malpractice sult commence					
lave you been a defenda	ent in any criminal proceeding other t	han minor traffic offenses co	mmenced since 10/1/83?		4	
	on been taken against you in the last ociation (international, national, state				by any	
has your privilege to post	sess, dispense or prescribe controlle	d substances ever been suspe	ended or revoked in this state	P OV BRY Office?	3 S S S	
	.E. requirements between 1/15/84 &	1/15/86 as follows: //	X- merting	84700)	AT ALSO KE	
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Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, Massachusetts 02111 1995-1997 Physician Registration Renewal Application

Registration No. Status Fee Renewal Date Late Fee 26760 INACTIVE \$250.00 07/20/95 \$25.00 Malling Address: 3143 NORTH 32ND STREET PHOENIX, AZ 85018	
Directions: Before proceeding, please read the instruction booklet. Some of	nuestions are optional.
• Failure to renew in a timely manner will cause your license to lapse at ability to practice medicine in the Commonwealth. (See enclosed letter	nd may affect your
Add late fee if necessary.	
 Make a copy of this form and all attachments for your own records - y credentialing and other purposes. The Board will charge a fee for each copy See instructions on detachable coupon at bottom of this page. 	y it provides.
Pre-Printed Information	BGARU OF REGISTRATION Corrections of Pre-Print All Information
1. Other name(s), if any, under which you were licensed:	Contraction of 110-11111 distribution in different
2. Home Address.	Name: Address: City/Town: State: Country:
3. Date of Birth: Sex: M Lic, Issue Date: / / SS#:	Date of Birth (M/D/Y):/ Sex (M/F): Lic. Issue Date (M/D/Y):/ SS#:
Home Phone Business Phone (602) 533-0446 4. Name of Medical School:	Home: Business: () Full Name of Medical School:
Albany Medical College of Union University Year Graduated: 60 Degree: MD	Year Graduated: Degree (MD/DO):
5. a) Other states where you are now licensed to practice (Abbr): b) States where you previously were licensed to practice (Abbr): CT	CA IL TX UX
6. Specialty Code(s) (See Table 1): Code Hours per Week in Mass.	Code Hours per Week in Mass.
GYN 0 Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (Se	pe Table 2)
Code: Code:	Code: Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts	Federal (DEA);Mass:
9. Activity Status: I am applying to be registered with the following status	: ACTIVE INACTIVE

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

PRINT NAME AND NUMBER: Physician Last Name: Bettigole Registration Number: 26760	ار
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code: /(AP) Facility Code: /(AP)	_
Facility Code: /(AP)	
If 999, print name(s):	
b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 year (See Table 3)	rs.
Facility Code: Fac	
If 999, write name(s): AVIZENE CHLY -Good Somewiten Melegy/Conder	_
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, check one. List Insurer: 5 = 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts:	_
12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes No (Check one)	
13. a) What is your principal work setting? (See Table 4)	
b) Care of patients in Massachusetts (See instruction booklet.)	
i) How many hours per typical week are you currently involved in outpatient care in Mass? hrs/wk	
 ii) How many hours per typical week are you currently involved in inpatient care in Mass? hrs/wk c) Approximately what percentage of your patient care hours are in primary care? 	
(See instructions for definition of primary care.)	
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.	
IN THE PAST TWO YEARS:	2
14. CLAIMS MADE: Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	
15. CLAIMS RESOLVED: Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?	
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?	
17. Have you been charged with any criminal offense, other than a minor traffic violation?	
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?	
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?	
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?	
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?	
 23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice? 24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition? 	
25. I have completed my CME requirements in the two years preceding my renewal date: Yes No, waiver requested No, training program exemption (see instruction booklet)	
If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.	
 Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges. 	
 Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief. I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States. 	3
 Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A. 	
· I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.	
Signature: Date: 71/195	
<i>i</i> /	

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OARD OF REGISTRATION IN MEDICINE ROOM 1507 — 100 CAMBRIDGE STREET BOSTON, MASSACHUSETTS 02202 RENEWAL APPLICATION 1986-1988 ,

IMPORTANT - READ, COMPLETE AND SIGN -

YOU MUST SIGN BELOW

				APPLICANT'S SIGNATURE					
LICENSE NUMBER			PAY THIS	FEE	DATE TO BE RENEWED				
.000E	TYPE	REGISTRATION NO.	AMOUNT		MO	DA	YR	LATE FEE	
MD		26760	100.00	100.00	01	15	86		

JOEL B BETTIGOLE

PLEASE PRINT ANY NAME OF ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

SEE REVERSE SIDE

PURSUANT TO M.G.L. C. 82C, § 49A, I. CERTIFY UNDER THE PENALTIES OF PERJURY THAT, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAXES REQUIRED UNDER LAW.

SEE REVERSE SIDE

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE REQUIRED UNDER LAW. THE ENCLOSED INSTRUCTIONS FOR DETAILS.) IF YOU ANSWERED "YES" TO ANY OF THESE QUES-TIONS, YOU MUST CHECK THIS BOX:

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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



PAYABLE TO: COMMONWEALTH OF MASSACHUSETTS PAYABLE TO: P.O. BOX 6 BOSTON, MASSACHUSETTS 02297

3500600267609 011586 10000000004

Print Name: Joel B. Bettisde, mo
Medical School: A Linguist madical College Date of Graduation: See Self-Go
1. Principal Specialty (sea): Administration, OR-GYN 2 Principal and Harris 1
3. Home address: 50 kg @ 5 Pro_ + 4. Principal business address: POROX POR 1 Principal business address: POR 1 Principal business address ad
5. List all hospitals at which you have currently effective privileges: 20019
6. States other than Messachusetts in which you are licensed to practice: Avizona
7. Have you been a defendant in any mal practice suit commenced since 10/1/83?
Have you been a defendant in any criminal proceeding other than misor traffic offenses commenced since 10/1/83? Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility; or by any professional medical association (international, national, state or locally).
16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?
11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: ACC - M. Parking Set 1 (50) GT - 1/15/86 as follows: ACC