Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

COMPLETED

Physician Registration Renewal Application

COMPLETED

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

REDACTED COPY

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

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

1. Current Status: Active Registration No.: 60491 Renewal Date: 04/28/2001

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

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

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

3. A) Mailing/Business Address:
ALAIN LESTER CAMPBELL
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

B) Home Address:

RECEIVED
APR 24 2001
Board of Registration in Medicine

Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (781) 592-3000

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____

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

4. a) Date of Birth: b) Sex: M

c) SS#:

5. a) Name of Medical School:
McGill University Faculty of Medicine

b) Year Graduated: 1976 c) Degree: M.D.

6. Specialty Code(s) (See Table 1)
Code(s) Hours per Week in Mass. 40

OBG 0 Obstetrics and Gynecology
0

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

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

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

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

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

Facility Code: 537 / ✓ (AP) 10 % Facility Code: 538 / ✓ (AP) 10 % Facility Code: ___ / ___ (AP) ___ %
Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ % Facility Code: ___ / ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: [illegible] LICENSE NUMBER: 84771

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

Name of Insurer: PRO MUTUAL # 1-31022 Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 35 hrs/wk b) inpatient care 5 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 5 %

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 04/19/01

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

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

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

Commonwealth of Massachusetts Board of Registration in Medicine

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

Physician Registration Renewal Application

RECEIVED
APR 27 1999
Board of Registration in Medicine

Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.
- **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 BRIGHT envelope.**

Registration No.: 60491 Renewal Date: 04/28/1999 1. Current Status: Active

V to BR

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

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

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

3. A) Mailing/Home Address:

ALAIN LESTER CAMPBELL, M.D.

B) Business Address:
ATLANTICARE OB/GYN
9 BOSTON STREET
EAST LYNN, MA 01904

Home Phone:
Business Phone: (781)592-3000

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

5. A) Name of Medical School:
McGill University Faculty of Medicine
B) Year Graduated: 1976 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	40	Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

Mailing Address: 9 Boston ST, Suite 9
City/Town: LYNN State: MA.
Zip: 01904 Country: USA

HOME: PLEASE DO NOT CIRCULATE.
Other Address: ____
City/Town: ____ State: ____
Zip: ____ Country: ____

Home: ( ) _____
Business: ( ) _____

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

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

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

PRINT NAME AND NUMBER: Last Name: CAMPBELL Registration Number: 60491

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

Facility Code: 81 ✓ (AP) 48 % Facility Code: 421 ✓ (AP) 4 % Facility Code: 141 ✓ (AP) 48 %

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

If 999, print name(s): _____

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

Name of Insurer: MEDICAL INTER. INS EX # 100437721 BROKER MBS INSURANCE Alternatively, indicate as follows:

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 36 hrs/wk b) inpatient care 4 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

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

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

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

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

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

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

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

Signature: _____ Date: 04/26/99

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

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

Physician Registration Renewal Application

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

Registration No.: 60491 Renewal Date: 04/28/97

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

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

3. A) Mailing/Home Address:

ALAIN LESTER CAMPBELL, M.D.

B) Business Address:
ATLANTICARE OB/GYN
9 BOSTON STREET
LYNN, MA 01904

Home Phone:
Business Phone: (617)592-3000

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 10/19/88 D) SS#:

5. A) Name of Medical School:

McGill University Faculty of Medicine
B) Year Graduated: 76 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	64	Obstetrics and Gynecology

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

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

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

Corrections (type or print)

Other Name(s): _____

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

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

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

Code(s)	Hours Per Week in Mass.
OBG	40 Obstetrics And Gynecology
___ ___ ___	_____

If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ____ ____ ____ ____
Abbr: ____ ____ ____ ____

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

LL

PRINT NAME AND NUMBER: Last Name: CAMPBELL Registration Number: 60491

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

Facility Code: 0 08 /✓(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
Facility Code: 0 1 4 /✓(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
If 999, print name(s): _____

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

Facility Code:____ Facility Code:____ Facility Code:____ Facility Code:____ Facility Code:____

If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ____b) Letter of Credit

Name of Insurer: AMERICAN MEDICAL MUTUAL

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a)____ Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 1 5

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

1) Average weekly hours involved in: a) outpatient care 32 hrs/wk b) inpatient care 8 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 5 %

PART A

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

IN THE PAST TWO (2) YEARS:

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

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

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

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature _____ Date: 02/25/97

Wallet Co. Dr. on 5/24/95 KB

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
60491	ACTIVE	$250.00	04/28/95	$25.00

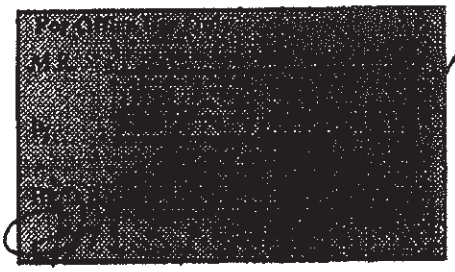
Mailing Address:
ALAIN LESTER CAMPBELL, M.D.

Correction of Mailing Address

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

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

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



Pre-Printed Information

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

2. Business Address:
ATLANTICARE OB/GYN
493 WESTERN AVENUE
LYNN, MA 01904

3. Date of Birth: Sex: M
Lic. Issue Date: 10/19/88 SS#:

Home Phone | Business Phone
(617)592-3000

4. Name of Medical School:
McGill University Faculty of Medicine
Year Graduated: 76 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): NONE
b) States where you previously were licensed to practice (Abbr): Quebec, CANADA

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

Code	Hours per Week in Mass.
OBG	64

Obstetrics and Gynecology

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

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

Corrections of Pre-Printed Information

Name: ATLANTICARE OB/GYN
Address: 225 BOSTON ST, SUITE 205
City/Town: LYNN
State: MA Zip: 01904
Country: USA

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

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____

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

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
_____	_____
_____	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE X 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: CAMPBELL Registration Number: 60491

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: 014 / X (AP) Facility Code: 008 / X (AP) Facility Code: ___ / ___ (AP)

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

If 999, print name(s): _____

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

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

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit ___ If applicable, check one.
List Insurer: Medical Mgt. Joint Underw. Ass., MA

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

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

13. a) What is your principal work setting? (See Table 4) 10

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? 17 hrs/wk
ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 45 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 0 %

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 X 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: 04/28/95

I. PHYSICIAN INFORMATION

ALAIN LESTER | | CAMPBELL |
First Name | Middle Initial | Last Name | Suffix

Make changes to name here

Mass License # 60491 | First Issue Date 10/19/88
License Status Active

Hospital Affiliation

Atlanticare Ob/Gyn
225 Boston St,Suite 205
Lynn, MA 01904
U.S.A.
(617) 592-3000

AtlantiCare Medical Center
North Shore Medical Center-Salem Hosp

Make address corrections here:
ATLANTICARE OB/GYN
9 BOSTON ST
LYNN, MA 01904, USA
(617) 592-3000

Make any corrections to above here:

Insurance Plan Affiliation:
HARVARD-TUFTS-BCBS
PRIVATE, IDEMNITY PLANS, HMOs,
PPO, MEDICARE, MEDICAID

Licenses Held in Other States:

(Please correct as necessary)

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

II. EDUCATION & TRAINING

McGill University Faculty of Medicine | MD | 76
Medical School | Degree | Date

Make corrections here
McGILL UNIVERSITY - MONTREAL GENERAL HOSPITAL - JEWISH GENERAL HOSPITAL July 76 To End JUNE 77
Residency Program(s) Start
UNIVERSITY OF MONTREAL GENERAL SURGERY UROLOGY HOTEL-DIEU HOSPITAL July 77 to End JUNE 78
Residency Program(s) Start
UNIVERSITY OF MONTREAL HOTEL-DIEU HOSPITAL - STE-JUSTINE HOSP-TERTIARY CENTER July 78 To End JUNE 80
Residency Program(s) Start

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

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

.....

.....

VII. MALPRACTICE

Details of claims paid for Dr. CAMPBELL

No. of Years in Practice: #

Date	Amount Paid 0.0000	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....
Date	Amount Paid	Basis for Complaint	.....

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, Honors	Publications
1972 STUDENTSHIP, NATIONAL RESEARCH COUNCIL OF CANADA	.....
1972-73 RESEARCH BURSARY, McGILL UNIVERSITY	.....
1976 M.Sc. DEGREE, EXPERIMENTAL MED. (ENDOCRINOLOGY), McGILL UNIVERSITY	.....
.....	.....
.....	.....
.....	.....

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

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

Registration No.	Status	Fee	Renewal Date	Late Fee
60491	ACTIVE	$250.00	04/28/93	$25.00

Mailing Address:
ALAIN LESTER CAMPBELL, M.D.

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

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

For Office Use Only
M.R. APR 27 1993
Pr. APR 27 1993
BK/D.B. 7287B EN

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):
   ATLANTICARE OB/GYN
   493 WESTERN AVENUE
   LYNN, MA 01904

3. Date of Birth: Sex: M
   Lic. Issue Date: 10/19/88 SS#:
   Telephone Number:
   Home Business
   (617)592-3000

4. Name of Medical School:
   McGill University Faculty of Medicine
   Year Graduated: 76 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): NONE
   b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.	
OOG	64	Obstetrics and Gynecology
	0	

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

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

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

Corrections of Pre-Printed Information

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

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____
Telephone Number:
Home: ( ) Business: ( )

Full Name of Medical School: _____

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

Quebec

Code	Hours per Week in Mass.

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

Federal (DEA): _____
State (MA): _____

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: CAMPBELL Registration Number: 60491

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: MED. MALP. JOINT UNDERW. ASS., MA.

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 0 0 8 / X (AP) Facility Code: 0 6 2 / X (AP) Facility Code: ___ / ___ (AP)
Facility Code: 0 1 3 4 / X (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 1 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? 34 hrs/wk in MA
ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 30 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:

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

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

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

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

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

Signature: [signature] Date: 4/26/93

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

HAND Delivered

Registration No.	Status	Fee	Renewal Date
60491	ACTIVE	$150	04/28/91

Dr. ALAIN LESTER CAMPBELL

For Office Use Only

M.R. ____ ___/___/___
Pr. ____ ___/___/___
Bk. ____ ___/___/___
Ch. BA 4/29/91
D.E. ____

Directions:

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

Activity Status:

I am applying to be registered with the following status: Active XX Inactive ____

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

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

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

Name: ____

2. a) Address (Home):

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

2. b) Address (Business):
ATLANTICARE OB/GYN
493 WESTERN AVENUE
LYNN, MA 01904-

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

3. Date of Birth: Sex: M
Lic. Issue Date: 10/19/88 SSN #:
Telephone Number:
Home Business
(617)592-3000

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

4. Medical School Code: QU001 Year Graduated: 76 Degree: MD
Name of School:
Faculty of Medicine, McGill University

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

5. a) Other States where you are now licensed to practice (*Abbr*): none
b) States where you previously were licensed to practice (*Abbr*): Quebec, Canada

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

Code	Hours per Week in Mass.	
03G	0	Obstetrics and Gynecology
	0	

Code	Hours per Week in Mass.
___	64
___	

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:
Code: 0G Board of Obstetrics and Gynecology
Code:

Code: ____
Code: ____

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

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

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

FILL IN NAME AND NUMBER:

Physician Last Name: CAMPBELL ALAIN LESTER Registration No.: 60491

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

List Insurer: MED. MALP. JOINT UNDERW. ASS., MA.

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

(State how otherwise exempt):_____

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

Facility Code: 008 xx(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

Facility Code: 014 xx(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

If 999, write Name(s):_____

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

Facility Code: 998 Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

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

b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow____ or iii) Research Fellow____? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program?_____hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 14 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 50 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 10

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

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

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

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

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

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

Signature: [signature] Date 4/27/91

98-00806

AFD

THE COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — $150.00 must accompany APPLICATION — No currency or personal checks)

Filed 4/7/88
By JML
Form of Fee CK

For Office Use

Application # 64040
Certificate # 60491 Date of Issue 10/19/88

Please Print

SWORN STATEMENT

Date: March 11th, 1988.

Name Alain (First) Lester (Middle) CAMPBELL (Last)

Address 7375 de Dieppe Ave.,
Montreal, Quebec, Canada.
H3R 2T6

Date of Birth —

Place of Birth St-Hyacinthe, Quebec, Canada

Pre-Medical Education

School University of Montreal

Years Attended B.Sc. : 1969-72
previously: B.A. (Univ. Mtl, 1969)

Medical Education

School McGill University

Years Attended 1972-76 : M.D., C.M.

Postgraduate Education & Hospital Appointments

Place	Position	Dates
McGill Univ.	POSTGRADUATE EDUCATION: M.Sc (Experimental Medicine - Endocrinology)	1972-1976
	Residency program: OB/GYN: McGill Univ. and Univ. Mtl;	1977-80
	Appointments: Assistant Prof Clinical OB/GYN, Fac Medicine and Graduate Studies, Univ. Montreal, Ste-Justine and Hôtel-Dieu	
University Hospitals;		1981-actual 1988;

List all other states in which you have been fully licensed: QUEBEC, only, Canada. 77-182

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

I never took the Canadian L.M.C.C. or F.R.C.P.C. exams;
This application for full licence or licence restricted to OB/GYN
as I am certified by an American Specialty Board. I have
made a commitment to join an OB/GYN practice at Atlantic Care
Medical Center, in Lynn, Mass., on July 1ST 1988; which is a
designated Medically Underserved area in OB/GYN; they are relying
on me to begin treating patients on July 1ST 1988

Thank you

J. Campbell M.D.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
FULL LICENSE

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alain L. CAMPBELL
PERMANENT ADDRESS: ---

LOCAL MAILING
ADDRESS IN (MA):

HOSPITAL: Ste-Justine Hospital
ADDRESS: 3175 CÔTE SAINTE-CATHERINE,
Montreal, Quebec, Canada.
H3T 1C5

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.	
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.	
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.	
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.	
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.	
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____, _____.	18.	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Alain L. Campbell DATE: March 11th, 1988

HAND Delivered 4/21/89

Commonwealth of Massachusetts Board of Registration in Medicine 008264
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

Board Use Only:

Registration No.	Status	Fee	Renewal Date
60491	1	$150	04/28/89

ALAIN LESTER CAMPBELL

M.R. BR 4/21/89
Pr.
Bk. 4/21/89
Ch.
D.E. 4/21/89
Fl.

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

1. a) Name (LAST:) CAMPBELL (FIRST:) ALAIN (M.I.:) L

1. b) Other Name(s), if any, that you were ever licensed under: NOT APPLICABLE

2. a) Address (Mailing): SAME AS ABOVE

2. b) Address (Home): SAME AS ABOVE

2. c) Address (Business): ATLANTICARE OB/GYN
493 WESTERN AVE., LYNN, MA. 01904

2. d) Telephone (Business): (617) 592-3000 Extension ____ 2. e) Telephone (Home) *(Optional)*: (___) ___-____

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

6. a) Medical School Code *(See Table 1)*: QU001 *If 99999, write* Name: ____

6. b) Year Graduated: 1976 6. c) Degree: M.D. XX D.O. ___

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

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

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

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

10 Resident or Fellow	___ %	20 Practice Involving Direct Patient Care	90 %
30 Administrative Activities	___ %	40 Medical Teaching	___ %
50 Medical Research	10 %	99 Other	___ %

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 1019/88

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

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

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

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*
Facility Code: 008 100% Facility Code: ___ ___ ___% Facility Code: ___ ___ ___%
Facility Code: ___ ___ ___% Facility Code: ___ ___ ___% Facility Code: ___ ___ ___%

If 999, write Name(s): ____

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*
Facility Code: 998 Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write Name(s): 998: MONTREAL: STE-JUSTINE UNIVERSITY HOSPITAL
MONTREAL: HOTEL-DIEU UNIVERSITY HOSPITAL

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

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

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) 3 attached pages--is true.

Signature: M Campbell (see reverse side) Date: April 21, 1989

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

Fill in name and number. **Physician Last Name:** CAMPBELL **Registration No.:** 60491

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

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

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

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 40 hrs., Category II: 60 hrs., (Risk-Management: 10 hrs.); Residency Program in: _____;
Waiver Requested ___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER ✓ LETTER OF CREDIT ___. *If applicable, check one and identify the name.*
Insurer: MED MAL. JOINT UNDERW ASS. MA Institution Issuing Letter of Credit: _____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE ___ OTHERWISE EXEMPTED ___ *(State how)* _____

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

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

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations–*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		

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

****

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

	Yes	No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___		

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
AMERICAN SPECIALTY BOARD

FOR OFFICE USE ONLY
Specialty License Application ____
Pending ____ Approved ____
License # ____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: CAMPBELL DR ALAIN L - HOSPITAL: ____

PERMANENT ADDRESS: ____

LOCAL MAILING: as before ADDRESS: ____

ADDRESS IN (MA): ____ Applying on the basis of which approved American Specialty Board? OB/GYN

Certificate Category? ____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?		
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever failed an American Specialty Board examination?		
8. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
9. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?		
10. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
11. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.		
12. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
13. Have you ever, for any reason, lost American Specialty Board Certification?		
14. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? ____		
15. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
16. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
17. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
19. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
20. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. QUEBEC # 77-182		

NOTE ON QUESTIONS 17-19: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #20 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for American Specialty Board Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: ____ DATE: July 12th, 1988

88-00806

AFD

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION AND DISCIPLINE IN MEDICINE

Application for Endorsement Registration

(Fee — $150.00 must accompany APPLICATION — No currency or personal checks)

Filed: 4/7/88
By: JML
Form of Fee: CK

For Office Use

Application # 64040
Certificate # 60491
Date of Issue 10/19/88

Please Print

SWORN STATEMENT

Date: March 11th, 1988.

Name: Alain (First) Lester (Middle) CAMPBELL (Last)

Address: _____

Date of Birth: _____

Place of Birth: St-Hyacinthe, Quebec, Canada

H3R 2T6

Pre-Medical Education

School: University of Montreal

Years Attended: B.Sc. : 1969-72
previously: B.A. (Univ. Mtl, 1969)

Medical Education

School: McGill University

Years Attended: 1972-76 : M.D., C.M.

Postgraduate Education & Hospital Appointments

Place	Position	Dates
POSTGRADUATE EDUCATION: M.Sc. (Experimental Medicine - Endocrinology)	McGill Univ.	1972-1976
Residency program: OB/GYN: McGill Univ. and Univ. Mtl;		1977-80
Appointments: Assistant Prof Clinical OB/GYN, Fac Medicine and Graduate Studies, Univ. Montreal, Ste Justine and Hôtel-Dieu		
University Hospitals;		1981-actual 1988;

List all other states in which you have been fully licensed: QUEBEC, only, Canada: 77-182

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

I never took the Canadian L.M.C.C. or F.R.C.S. exams;
This application for full licence or licence restricted to OB/GYN as I am certified by an American Specialty Board. I have made a commitment to join an OB/GYN practice at Atlantic Care Medical Center, in Lynn, Mass., on July 1st 1988, which is a designated Medically Underserved area in OB/GYN; they are relying on me to begin treating patients on July 1st 1988

Thank you

Alain Campbell M.D.

COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
SUPPLEMENT TO APPLICATION FOR
FULL LICENSE

FOR OFFICE USE ONLY
Full License Application ____
Pending ____ Approved ____
License # _____

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alain L. CAMPBELL

PERMANENT ADDRESS: _____

LOCAL MAILING ADDRESS IN (MA): _____

HOSPITAL: Ste-Justine Hospital

ADDRESS: 3175 CÔTE SAINTE-CATHERINE, Montreal, Quebec, Canada H3T 1C5

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.	YES	NO
1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?	1.	
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	2.	
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?	3.	
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?	4.	
5. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards?	5.	
6. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	6.	
7. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution, denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?	7.	
8. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state, or local)?	8.	
9. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.	9.	
10. Have you ever withdrawn an application for medical licensure, hospital priviledges or appointment, for any reason?	10.	
11. Have you ever for any reason, lost American Specialty Board Certification?	11.	
12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?	12.	
13. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	13.	
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	14.	
15. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	15.	
16. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	16.	
17. Are you now, or have you been in the past, dependent upon alcohol or drugs?	17.	
18. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. _____, _____, _____, _____.	18.	

NOTE ON QUESTIONS 15-17: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #18 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary. I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form (front and back) including attached sheets is true.

SIGNATURE: Alain L. Campbell DATE: March 11th, 1988

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2005 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

2005 MAR 28 PM 2:04

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

3) E-mail Address: NOT AVAILABLE AT OFFICE

4) Fax Number: 781-592-9625

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

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

List Certifying Board(s) below:

Board Name	**ABMS**	**AOA**
AMERICAN BOARD OBSTETRICS GYNECOLOGY	☒	☐
	☐	☐
	☐	☐
	☐	☐

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Certificate/Subspecialty	**Correct?**	**Delete?**
Obstetrics & Gynecology	☒	☐
	☐	☐
	☐	☐
	☐	☐

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)** NONE
a) Massachusetts:	
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)** QUEBEC
c) Federal (DEA) XS:	

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

Principal Work Setting: Private Office Change to: _____

Please enter principal work setting hours per week here: 18-20

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

No Affiliations ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category		# Hours per Week
		Current	Change	
North Shore Medical Center - Salem Hospital	☐	Admitting		0.5
Union Hospital	☐	Admitting		1
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 5 hrs/wk Change to: 1 hrs/wk

b) outpatient care 30 hrs/wk Change to: 18-19 hrs/wk

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

My medical liability insurance is provided through: (check one)

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

Current Insurance Carrier: ProMutual Group 1-31022 Change to: _____

Policy dates: From 02/07/05 To 02/07/06 *(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain)*: _____

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.:** 60491

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: ALAIN LESTER CAMPBELL **License No.: 60491**

PHYSICIAN PROFILE

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

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

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 03/28/05

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

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

Rec'd 4-1-03

Physician Registration Renewal Application

RECEIVED
APR 11 2003
Board of Registration in Medicine

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

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 60491 Renewal Date: 04/28/2003

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

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

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

3. A) Mailing/Business Address:
ALAIN LESTER CAMPBELL
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (781) 592-3000

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____
PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

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

5. a) Name of Medical School: McGill University Faculty of Medicine
b) Year Graduated: 1976 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	35	Obstetrics and Gynecology
0		
0		

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

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

9. a) Other states where you are now licensed to practice (Abbr.) NONE

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

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

Facility Code: 537/L (AP) 5 % Facility Code: 538/L (AP) 10 % Facility Code: ___/___ (AP) ___ %
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: CAMPBELL LICENSE NUMBER: 60491

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

Insurer's name. (Required): PRO-MUTUAL: 1-31022 Policy dates: From: 02/07/03 To: 02/07/04

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

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 5 hrs/wk B) outpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 5 %

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

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

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

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

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

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

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

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

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

Signature: M Campbell Date: 04/07/03

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

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

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

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

Rec'd 4-11-03

Physician Registration Renewal Application

RECEIVED
APR 11 2003
Board of Registration in Medicine

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

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

Please review carefully the following information for accuracy and completeness. Make any corrections or alterations as required. All questions must be answered or your renewal will be delayed.

1. Current Status: Active Registration No.: 60491 Renewal Date: 04/28/2003

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

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

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

A) Mailing/Business Address:

3. ALAIN LESTER CAMPBELL
9 BOSTON STREET
SUITE 9
LYNN, MA 01904-0000

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (781) 592-3000

Home Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Home Telephone: _____

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

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

5. a) Name of Medical School: McGill University Faculty of Medicine
b) Year Graduated: 1976 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	35	Obstetrics and Gynecology
0	0	

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

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

9. a) Other states where you are now licensed to practice (Abbr.) NONE

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

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

Facility Code: 537/L (AP) 5 % Facility Code: 538/L (AP) 10 % Facility Code: ___/___ (AP) ___ %
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: CAMPBELL LICENSE NUMBER: 60491

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

Insurer's name. (Required): PRO-MUTUAL : I-31022 Policy dates: From: 02/07/03 To: 02/07/04

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

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 1 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care 5 hrs/wk B) outpatient care 30 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 5 %

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 04/07/03

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

Current Status: Active **License Expiration Date:** 4/28/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:
Cardone & Asso Rep Med, 2 Main St
Suite 150
Stoneham
Massachusetts - 02180
United States of America

Home Address:

Business Address:
2 MAIN ST, CARDONE & associates rep med
Suite 150
Stoneham
Massachusetts - 02180
United States of America
(781) 592-3000

3) **Email Address:**

4) **Fax Number:** (781) 438-9601

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**
New Hampshire

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
	None Reported

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 10 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Medical Professional Mutual Ins Co	02/07/2011	02/07/2012	Occurrence Policy

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

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

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

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

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

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

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

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

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

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

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

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

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

Current Status: Active **License Expiration Date:** 4/30/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:
Cardone & Asso Rep Med, 2 Main St
Suite 150
Stoneham
Massachusetts - 02180
United States of America

Home Address:

Business Address:
2 MAIN ST, CARDONE & associates rep med
Suite 150
Stoneham
Massachusetts - 02180
United States of America
(781) 592-3000

3) Email Address:

4) Fax Number: (781) 438-9601

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
New Hampshire

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
	None Reported

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 0 hrs/wk
b) outpatient care 1 hrs/wk

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Other

Lymphoma Chemo Dec Jun 2012 comp including 3 hops Sept. Dec. many days IV abx. Adm asthma Dec, severe neutropenia Ap 23 170 ANC No patient since chemo no wish to retire insurance costly; take when stable Inactive lic long to re-establish.

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

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

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

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

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

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

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

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

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

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

23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
Lymphoma Dec.2011, at Mass MGH Chemo.Dec Jun2012;complications; insurance not renewed per 243 CMR 2.07 (16)(d)not engaged in practice;have tail; will re-activate when stable

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

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

Compliance with Legal Responsibilities

Online profile:

[X] I have reviewed my Physician Profile and confirm that the information is accurate.

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

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

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

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

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

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

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

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

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

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

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Dr. Alain Lester Campbell

License Number: 60491

Data Date

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.

Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).

Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

☐ My current NPI is: ☐☐☐☐☐☐☐☐☐☐

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207V00000X	OBSTETRICS & GYNECOLOGY
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): _____ Country of Birth (if outside the US): CANADA

Gender: ☒ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

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

Signature: M Campbell Date: 02/11/2007

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dr. Alain Lester Campbell
9 Boston Street
Suite 9
Lynn, MA 01904-0000

01/25/2007

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane MD

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.:** 60491

PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2007 **Birth Date**

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

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

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

2a) MAILING ADDRESS

9 Boston Street
Suite 9
Lynn, MA 01904-0000

APR 10 2007

☐ *Check here to change this address*

Please make corrections (print)

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

9 Boston Street
Suite 9
Lynn, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 781-592-9625

Correct your E-mail and Fax Number below:

_____

_____

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
North Shore Medical Center - Salem Hospital	SALEM	MA	☐
Union Hospital	LYNN	MA	☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 1 hrs/wk Change to: _____ hrs/wk

b) outpatient care 18 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 02/07/2007 To 02/07/2008

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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

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

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 03 / 23 / 07

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

Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite G-4
Boston, MA 02118
617-654-9810
www.massmedboard.org

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form. If you already have a NPI number, you may enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf. You must sign and date the NPI form to authorize the Board to provide the NPI to authorized entities. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

Please complete the NPI form on the following page.

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

Option 1: Supply the Board of Registration in Medicine with your valid NPI. You can apply for an NPI directly by using the NPPES Web site at www.NPPES.cms.hhs.gov.
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Number, you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org.
Option 3: Certify another authorized institution has applied for an NPI on your behalf and you have not received it yet (supply institution's name). Once you have received your NPI Number, you must notify the Board by completing the NPI form at the Board's website (see Option 2).
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.
Option 5: If your license status is INACTIVE, you may elect not to obtain an NPI number.

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

☒ My current NPI is: 1 1 8 4 7 5 3 3 6 0

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	OBSTETRICS- GYNECOLOGY
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): _____ Country of Birth (if outside the US): CANADA

Gender: ☒ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

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

Signature: _____ Date: 04/04/07

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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PART A

1) Current Status: Active **Renewal Due Date:** 03/31/2009 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
9 Boston Street
Suite 9
Lynn, MA 01904-0000

☐ *Check here to change this address*

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS
9 Boston Street
Suite 9
Lynn, MA 01904-0000

Phone: (781)592-3000

☐ *Check here to change this address*

APR 22 2009
Board of Registration in Medicine

3) E-mail Address:

4) Fax Number: 781-592-9625

Please make corrections (print)

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

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

Home address cannot be a Post Office Box

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

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		NH
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
North Shore Medical Center - Salem Hospital			☐
Union Hospital			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 1 hrs/wk Change to: _____ hrs/wk

b) outpatient care 18 hrs/wk Change to: 14 hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: ProMutual Group Change to: _____

Policy dates: From 02/07/09 To 02/07/10

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

04/22/09 S1

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

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

	YES	NO
14) CLAIMS MADE a) **NEW:** Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D. **License No.: 60491**

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PART C

CERTIFICATIONS

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

2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply. 88

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

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

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

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

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

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

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

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

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

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

Check One:

PHYSICIAN PROFILE

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

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

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

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

Signature: _____ Date: 03/27/2009

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