

Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-308

http://www.massmedboard.org

Physician Registration Renewal Application

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

- · Remit \$250.00 for renewal fee.
- · Add late fee of \$25.00, if necessary.

- · Return renewal application in GREEN envelope.
- · Enclose check with coupon in BLUE envelope.

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

1. Current Status:	Active	Registratio	on No.:60491	Renewal Date: 04/28/2001	
If you want to chan	ge your curre	nt status, please check	one of the fol	llowing boxes to indicate your new status: (Check only on	e)
Active [Retiring	(see instructions)	☐ Inactiv	ce (see instructions) Do not wish to renew	
2. Other Name(s), it	f anv. under v	which you were license	ed: _	Please make corrections (type or print)	
		,		Other Name(s):	
3. A) Mailing/Bus ALAIN LES 9 BOSTON : SUITE 9 LYNN, MA B) Home Addre	TER CAMPI STREET 01904-0000	BELL	A Start of the opening	Mailing Address: City/Town: Zip: Country: Business Address: City/Town: Zip: Country: Business Telephone: (781) 592-3000	
Home Phone:	- برغو العام			Home Address: City/Town: Zip: Country: Home Telephone:	
Business Phone:				PLEASE NOTE: No P.O. Box addresses for home or business addresses.	
4. a) Date of Birth:		b) Sex:	7. Curr	ent American Board of Medical Specialties Certification (! Gode: Code:	See Table 2
c) \$\$#;					
5. a) Name of Medica	l School:		a) E	g License Numbers, if any: Federal (DEA): Massachusetts:	
b) YMFGIAddaixe!	sity Faculty of 1976	of Medicine c) Degree: M.D.	9. a) C	Other states where you are now licensed to practice (Abbr.)	ı
6. Specialty Code(s) (S Code(s) Hour	iee Table 1) s per Week i	n Mass. 40	b) Si	tates where you were previously licensed (Abbr.)	
OBG 0	Obstetrics a	and Gynecology		· · · · · · · · · · · · · · · · · · ·	
the codes from Tal	ole 3 and plac	e a check mark next to	o those health	ntialing process for the provision of patient care. (Supply care facilities where you have admitting privileges (AP), e hours that you provide in each facility).	
Facility Code: 5 37/ Facility Code: / f 999, print name(s): _	(AP)	% Facility Code:	/ (AP) / 2 % Facility Code: / (AP) % AP)% Facility Code: / (AP)%	

PRINT YOUR LAST NAME: IVIT DECL LICENSE NUMBER: WOT	9/
112 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 Zh
13. A. What is your principal work setting? (See Table 4) _/ 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/w	· k
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 details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional informations. You must answer ALL questions, or this form will be returned to you and your license renewal may	ermation and
	YES NO
14. <u>CLAIMS MADE</u> : 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?	, f
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?	í
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, torminated 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
The court will be a second of the court of t	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 am	ount.
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 Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United	ali 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 rel 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, § 51/	1.
• I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is t	
Signature: Date: 04 1/	_

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

• Copy this form and all attachments for your own records; you wi	read the instruction booklet.			
 Remit \$250.00 for renewal fee. Add late fee of \$25.00, if necessary. 	• Return renewal application in GREEN Burglope. • Enclose check with coupon in BESS short dope Medicin			
Registration No.: 50491 Renewal Date: 04/28/	1999 1. Current Status: Active			
If you want to change your current status, please indicate below: (6	Check one).			
Active Retiring (see instructions)	tive (see below *) Do not wish to renew			
2. Other Name(s), if any, under which you were licensed:	Please make corrections (type or print)			
	Other Name(s):			
3.A) Mailing/Home Address:	Mellin Aldrew B 2			
ALAIN LESTER CAMPBELL, M.D.	Mailing Address: 9 BOSTON ST, SUITE 9 City/Town: LYNN State: MA.			
	Zip: <u>01904</u> Country: <u>USA</u>			
B) Business Address: ATLANTICARE OB/GYN 9 BOSTON STREET BAST LYNN, MA 01904	HOME: PLEASE DO NOT CIRCULATE. Other Address: City/Town: Zip: Country:			
Home Phone: Business Phone: (781) 592-3000 4. A) Date of Birth: B) SS#:	Home: (Business: (
5. A) Name of Medical School: McGill University Faculty of Medicine	Full Name of Medical School:			
B) Year Graduated: 1976 C) Degree: MD	Year Graduated: Degree: M.D. D.O.			
Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. ODG TO OBSTRETTICS and Gynecology	Code(s) Hours Per Week in Massachusetts			
	If OS, Print Specialty:			
Current American Board of Medical Specialties Certification (See Code: OG	Table 2) Code: Code:			
Drug License Numbers if any	Federal (DEA):			
A) Federal (DEA): B) Massachusetts:	Mass:			
A) Other states where you are now licensed to practice Abbr:	Abbr:			
B) States where you previously were licensed to practice Abbr:	Abbr:			

1	PRINT NAME AND NUMBER: Last Name: CAMPBELL Registration Number:	60	491
t	10. Current health care facilities at which you have completed the credentialing process for the provision of patient cache codes from Table 3 and place a check mark next to those health care facilities where you have admitting privilege each facility, write the approximate percentage of patient care hours that you provide in each facility.	are. Sup s (AP).	opiy Next to
I	Facility Code: 8/ V (AP) 48 % Facility Code: 42/ V(AP) 4 % Facility Code: 14/ V	(AP)	48%
I	Facility Code:/(AP) % Facility Code:/(AP) % Facility Code:/	(AP)	9
I	f 999, print name(s):	`	 -
1	1. My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Credit	***************************************	
1	Name of Insurer: MEDICAL INTEL INS EX # 100437721 Alternatively, indicate as follows: 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		
	ease explain exemption:		
12	. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one	\	TON
	. A. What is your principal work setting? (See Table 4) / 5		<u> </u>
	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/w	k	
	2) What is the approximate percentage of your patient care hours in primary care? 10 %	·	
<u>P/</u>	ART A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS		
de	estions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each questi- tails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional info finitions. You must answer ALL questions, or this form will be returned to you and your license renewal may	rmetio	heer
		YES	NO
14.	<u>CLAIMS MADE</u> : 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.	<u>CLAIMS RESOLVED:</u> 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?		1
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?		1
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?		ļ
	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?		ļ.
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 Progra	m exem	ption
Sec	Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal applicati		•
•	Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedu	le amour	ıt.
•	Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and Massachusetts state taxes that are required under law. <u>NOTE</u> : This applies even if you reside out-of-state or out of the Us	paid all	tes.
	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, §		
	I hereby certify under the penaities of perjury that all the information on the Renewal Application and Form R is		
	ature: Date: 04 /		99
	YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLIC		



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.

· Ref	urn	renewal	application	in	GREEN	envelo	pe.
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· Enclose check with coupon in BLUE envelope.

Projection No. 10 April 10 Apr	97		
Registration No.: 60491 Renewal Date: 04/28/ I. Activity Status: Active Retiring Retiring Do not with the control of the cont	(see instructions)		
2. Other Name(s), if any, under which you were licensed:	Corrections (type or print)		
	Other Name(s):		
3. A) Mailing/Home Address:	Mailing Address:		
ALAIN LESTER CAMPBELL, M.D.	City/Town: State:		
	Zip: Country:		
B) Business Address:	Other Address:		
ATLANTICARE OB/GYN 9 BOSTON STREET	City/Town: State:		
LYNN, MA 01904	Zip: Country:		
Home Phone:	Home: (
Business Phone: (617) 592-3000	Business: ()		
4. A) Date of Birth: C) Sex: M	Date of Birth (M/D/Y):/ Sex (M/F):		
B) Lic. Issue Date: 10/19/88 D) SS#:	Lic. Issue Date (M/D/Y):/ SS#:		
5. A) Name of Medical School:	Full Name of Medical School:		
McGill University Faculty of			
Medicine B) Year Graduated: 76 C) Degree: MD	Year Graduated: Degree (MD/DO):		
6. Specialty Code(s) (See Table 1)	Code(s) Hours Per Week in Mass.		
Code(s) Hours per Week in Mass.	0BG 40 Obstetrics AND GYNGCOLOGY		
OBG 64 Obstetrics and Gynecolo	If OS, Print Specialty:		
 Current American Board of Medical Specialties Certificati Code: og Code: 	(See Table 2) Code: Code:		
8. Drug License Numbers, if any:	E-1-1/DEA)		
A) Federal (DEA): B) Massachusetts:	Federal (DEA):		
9. A) Other states where you are now licensed to practice Abbr:	Abbr:		
B) States where you previously were licensed to practice 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
Table 3 and place a check mark next to those he Facility Code: • 68/(AP)	completed the credentialing process for the provision of patient care. Sue alth care facilities where you have admitting privileges (AP). Facility Code: / (AP) Facility Code: Facility C	
 B. Additional health care facilities at which you (See Table 3) 	previously held privileges or with which you were associated in the pas	t two (2) years.
Facility Code: Facili	Facility Code: Facility Code: Facility Code:	
	EDICAL MUTUAL	
	ering with Active status but I am not covered by medical malpractice insudirect/indirect patient care in Massachusetts b) Otherwise exempt	rance because
12. Are you currently in a post-graduate training progr13. A. What is your principal work setting? (See Table	ram in Mass. as a resident or clinical fellow? (check one)	Yes Kan
	on booklet). a) outpatient care 32 hrs/wk b) inpatient care 8 hrs/ ur patient care hours in primary care ? 5 %	wk
PART A Questions 14 through 22 refer to the past two (2 details on Form R for all YES answers except for definitions.	2) years only. Check either YES or NO (NOT N/A) to each quor question 22. Refer to the instruction booklet for additional	estion. Provide information and
IN THE PAST TWO (2) YEARS:		YES NO
14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in re		YES NO
14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in re	elation to the claim? actice claim that has been made against you been settled, adjudicated, or	YES NO
 14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in resolved. 15. CLAIMS RESOLVED: Has any medical malpra otherwise resolved, whether or not a lawsuit was filed. Has any lawsuit, other than a medical malpractice is 	elation to the claim? actice claim that has been made against you been settled, adjudicated, or	YES NO
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 14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in resolved. 15. CLAIMS RESOLVED: Has any medical malpractice otherwise resolved, whether or not a lawsuit was filed. Has any lawsuit, other than a medical malpractice of professional conduct in the practice of medicine, be 17. Have you been charged with any criminal offense, of the Have you been formally charged with or disciplined governmental authority, health care facility, group of the second sec	elation to the claim? actice claim that has been made against you been settled, adjudicated, or led in relation to the claim? suit, which is related to your competency to practice medicine, or your een filed against you or been settled, adjudicated or otherwise resolved? other than a minor traffic violation? d for any violation of the rules, by-laws or standards of practice of any practice or professional society or association?	YES NO
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 14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in resolved, whether or not a lawsuit was filed in resolved. Has any medical malpractice otherwise resolved, whether or not a lawsuit was filed. Has any lawsuit, other than a medical malpractice is professional conduct in the practice of medicine, between the conduct in the	elation to the claim? actice claim that has been made against you been settled, adjudicated, or led in relation to the claim? suit, which is related to your competency to practice medicine, or your een filed against you or been settled, adjudicated or otherwise resolved? other than a minor traffic violation? d for any violation of the rules, by-laws or standards of practice of any practice or professional society or association? e controlled substances been surrendered to or suspended, revoked, icense or been denied a medical license for any reason?	YES NO
 14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in resolved, whether or not a lawsuit was filed in resolved. Has any medical malpractice is professional conduct in the practice of medicine, bether than a medical malpractice in the practice of medicine, bether the professional conduct in the practice of medicine, bether than a medical malpractice in the practice of medicine, bether than a medical malpractice in the practice of medicine, bether than a medical malpractice in the practice of medicine, bether than a medical malpractice in the practice of medicine, bether than a professional authority, health care facility, group in the practice of the practi	elation to the claim? actice claim that has been made against you been settled, adjudicated, or led in relation to the claim? suit, which is related to your competency to practice medicine, or your een filed against you or been settled, adjudicated or otherwise resolved? other than a minor traffic violation? d for any violation of the rules, by-laws or standards of practice of any practice or professional society or association? e controlled substances been surrendered to or suspended, revoked,	YES NO
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14. CLAIMS MADE: Has any medical malpractice of adjudicated, whether or not a lawsuit was filed in resolved, whether or not a lawsuit was filed in resolved. Has any medical malpractice is professional conduct in the practice of medicine, be 17. Have you been charged with any criminal offense, of the laws you been formally charged with or disciplined governmental authority, health care facility, group of the laws your privilege to possess, dispense or prescribed denied or restricted by any state or federal agency? 20. Have you withdrawn an application for a medical lite. Has any professional liability insurance provider replaced any condition related to professional competinited or terminated your insurance coverage in recommendation. Have you completed your CME requirements preceded. Waiver requested (waiver form due 30 days prince Instructions for CME requirements. Do not sure RENEWAL APPLICATION CONTINUED.	elation to the claim? actice claim that has been made against you been settled, adjudicated, or led in relation to the claim? suit, which is related to your competency to practice medicine, or your een filed against you or been settled, adjudicated or otherwise resolved? other than a minor traffic violation? d for any violation of the rules, by-laws or standards of practice of any practice or professional society or association? e controlled substances been surrendered to or suspended, revoked, icense or been denied a medical license for any reason? estricted, limited, terminated, imposed a surcharge or co-payment, or tency or conduct on your coverage or have you voluntarily restricted, esponse to an inquiry by a professional liability insurance provider? edding your renewal date (see instruction booklet)? rior to date of license expiration). Training Program exemption	ı.

World to states

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	C. A. H. W. W. Hiller, A. Admira
60491 ACTIVE \$250.00 04/28/95 \$25.00	
Mailing Address:	Address (Mailing):
ALAIN LESTER CAMPBELL, M.D.	City/Town:
	State:
	Country:
Directions: Before proceeding, please read the instruction booklet. Some q	puestions are optional.
 Failure to renew in a timely manner will cause your license to lapse as ability to practice medicine in the Commonwealth. (See enclosed letter) 	nd may affect your).
· Add late fee if necessary.	
· Make a copy of this form and all attachments for your own records -	you will need copies for
credentialing and other purposes. The Board will charge a fee for each cop	y it provides.
• See instructions on detachable coupon at bottom of this page.	
	Corrections of Pre-Printed Information
Pre-Printed Information	Corrections of Fier Lines Internation
1. Other name(s), if any, under which you were licensed:	Name: ATLANTICARE OB/GYN
2. Business Address:	Address: 225 BOSTON ST. SUITE 205
ATLANTICARE OB/GYN	City/Town: AYNA Zip: 01904
493 WESTERN AVENUE	Country: USA Zip: 187 289
LYNN, MA 01904	
3. Date of Birth: Sex: w	Date of Birth (M/D/Y):/ Sex (M/F):
3. Date of Birth: Sex: M Lic. Issue Date: 10/19/88 SS#:	Lic. Issue Date (M/D/Y):/_ SS#;
Lic. 1850c Date. 10/19/88 35%.	
Home Phone Business Phone	Home: () Business: ()
(617) 592-3000	Full Name of Medical School:
4. Name of Medical School:	
McGill University Faculty of	
Medicine	Year Graduated: Degree (MD/DO):
Year Graduated: 76 Degree: MD	
5. a) Other states where you are now licensed to practice (Abbr): NON 6 b) States where you previously were licensed to practice (Abbr): SUEA	se, canada
	Code Hours per Week in Mass.
6. Specialty Code(s) (See Table 1): Code Hours per Week in Mass.	
OBG 64 Obstetrics and Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (S	ee Table 2)
Code: OG Code:	Code: Code:
5000 U G	
8. Drug license number(s), if any: a) Federal (DEA)	Federal (DEA):
b) Massachusetts	Mass:
A A SENSON A TOTAL CONTRACTOR OF THE SENSON ASSESSMENT OF THE SENSON AS	18: ACTIVE X INACTIVE
9. Activity Status: I am applying to be registered with the following statu	
. Thought contifu that if upgrowting Impating status. I will not apporting	madicina including writing prescriptions in Massachusetts.

PRINT NA	AME AND NUMBER: Phy	ysician Last Name: _	CAMPBELL	Registration Nu	mber: <u>604</u>	141
codes from T	nt health care facility(ies) at which you able 3 and place a check mark next to t	have completed the	credentialing process for	r the provision of patient of	care. Supply the	`
Pacility	Code: / (AP) Fa	cility Code:	/ (AP)	Facility Code:	/ (AP)	
If 999, print	name(s):					
(See Tab	•				_	-
If 999, write	Facility Code:				²acility Code:	
11. My medic	al malpractice insurance is covered by List Insurer:	(a) Insurance Carrier P 60xT Und 34	(b) Letter of Cr ASS, Mf	redit If applied	able, check one.	
(Check One): State how of	ndicate as follows: I am registering w (i) Not involved in direct/indirect patient exempt:	ent care in Massachus	etts:	(ii) Otherwise exc	empt:	
12. Are you	currently in a post-graduate training pro	gram in Mass. as a re	sident or clinical fellov	v? Yes No _X	(Check one)	
13. a) What	is your principal work setting? (See T	able 4)	-			
i) H ii) H c) Appra	of patients in Massachusetts (See instruction many hours per typical week are you many hours per typical week are you many hours per typical week are you mately what percentage of your patienstructions for definition of primary can	u currently involved in currently involved in the care hours are in p	in inpatient care in Mas	11 9	6	
	14 through 24 refer to the past two y 1 and R-2 for all YES answers. Refer					
IN THE P	AST TWO YEARS:				YES	NO
	MADE: Has any medical malpractice d, whether or not a lawsuit was filed in				·	
15. CLAIMS whether or	RESOLVED: Has any medical malpro not a lawsuit was filed in relation to th	actice claim against ye e claim?	ou been settled, adjudic	ated or otherwise stable	L,	
fessional	wsuit, other than a medical malpractice conduct in the practice of medicine, bee	n filed against you by	a patient, or been settle	ed, adjudicated or otherwi	\$ 6	
	een charged with any criminal offense,					
	een formally charged with or disciplinatal authority, health care facility, group					
or restricte	rivilege to possess, dispense or prescrib d by any state or federal agency?	*********************	# = 43 (jr = 4 + 20 h = 2 + 2 + 2 + 2 + 2 + 2 + 2 + 2 + 2 + 2		*********	
20. Have you	vithdrawn an application for a medical	license or been denied	a medical license for a	ny reason?		
have you	ofessional liability insurance provider no oluntarily restricted, limited or termina surance provider?	ted your insurance co	verage in response to ar	n inquiry by a professiona]	
	een diagnosed with or do you have a m					
24. Have you v	ngaged in the use of any chemical subs oluntarily modified or otherwise limite	d your scope of practi	ce of medicine for any	reason other than a medic	al	
25. I have com	pleted my CME requirements in the tw g program exemption (see instruction b	o years preceding my	renewal date: Yes _	No, waiver requ	rested	-
If requesting	g a waiver you must fill out a separate see instructions for CME requirements.	Waiver Form. The w	aiver must be granted be mentation of your CME	y the Board before your list with your renewal applications.	icense will be	
	to G.L. c. 112, sec. 2, I will not charge					K.
I have filed all !	to G.L. c. 62 C, sec. 49A, I hereby cer Asssachusetts state tax returns and p le out-of-state or out of the United St	aid all Massachusett	and penalties of perjust s state taxes that are r	ry that, to the best of my equired under law. NO	knowledge and bel FE: This applies	lief,
• Pursuant	o G.L. c. 112, sec. 1A, I hereby certif 0, sec. 51A.		y obligation to report s	abuse or neglect of child	ren as required by	
· I hereby c	ertify under the pains and penalties o	perjury that all inf	ormation on this form	and Forms R-1 and R-2	is true.	
Signature:	DHG.	mobble		Date: 04	128,95	

ALAIN LESTER First Name	Middle Initia	CAMPBELL al Last Name		Suffix	
Make changes to name here					
Mass License #60491 License Status Active			First Issue Date 10/1	9/88	
		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 OF 9 BOSTON ST	~	Make any corrections to above he	re;		
19NN , MA 0190 (617) 592-300	00				
Insurance Plan Affiliati	on: L	icenses Held in Other States:			
HARVARD - TUFTS - BC PRIVATE, I DENNITY I PPO, MEDICARE, A	RS PLANS, HMOS, MEDICALD		Accepting New Patients? [Accept Medicaid?	XYes □ No	
	***************************************	(Please correct as necessary)			
. EDUCATION & TRAIN	<u>ING</u>				
McGill University Faculty o Medical School	f Medicine	MD Degree	76 Date	······	
Residency Program(s) WESSITY OF MONTREAL GOA	serac Surbery.	SPITAL LEWISH GENERAL Start UROLOGY HOTELDIEU HOS Start TAL-STE-LUSTINE HOSP Start	PITAL JULY 77 7	o End June	
I. SPECIALTY		BOARD CERTIF	ICATION		
	and Gynecology	Certifying Board Name: Board of Obstetrics and Gynecology			
econdary Specialty:		Certifying Board Nar	Certifying Board Name:		
lake any corrections here:		Make any corrections	s here:		

Board of Registration in Medicine

Physician Profile

	Final Decisions and orders issued by Nature	Date	
	X 1000042	Date	Board Action
v.	HOSPITAL DISCIPLINE Hospital	Date	Disciplinary Action
		activ.	escipanal) Action
VI.	included when the court system is ful	to obtain accurate data for this category at lly computerized. Please list any criminal	the present time. This information will be convictions. Include conviction date and natur
	4		
VII.	MALPRACTICE		
	MALPRACTICE Details of claims paid for Dr. CAM		No. of Years in Practice: #
	Details of claims paid for Dr. CAM Date Amount Pa	PBELL id 0 0000 Basis for Co	No. of Years in Practice: #
	Details of claims paid for Dr. CAM Date Amount Pa Date Amount Pa	PBELL id 0.0000 Basis for Co	No. of Years in Practice: #
	Details of claims paid for Dr. CAM Date Amount Pa Date Amount Pa Date Amount Pa	PBELL id 0.0000 Basis for Co id Basis for Co id Basis for Co	No. of Years in Practice: # omplaint omplaint
	Details of claims paid for Dr. CAM Date Amount Pa Date Amount Pa Date Amount Pa	PBELL id 0.0000 Basis for Co id Basis for Co id Basis for Co	No. of Years in Practice: # omplaint omplaint omplaint
	Details of claims paid for Dr. CAM Date Amount Pa	PBELL id 0.0000 Basis for Co id Basis for Co id Basis for Co id Basis for Co	No. of Years in Practice: # omplaint omplaint omplaint omplaint
	Details of claims paid for Dr. CAM Date Amount Pa Date Amount Pa Date Amount Pa	PBELL id 0.0000 Basis for Co id Basis for Co	No. of Years in Practice: # omplaint omplaint omplaint omplaint omplaint omplaint omplaint
	Details of claims paid for Dr. CAM Date Amount Pa	PBELL id 0.0000 Basis for Co id Basis for Co	No. of Years in Practice: # omplaint omplaint omplaint omplaint omplaint omplaint omplaint
VIII.	Details of claims paid for Dr. CAM Date Amount Pa PHYSICIAN HONORS & PEE Please enter any peer-reviewed public professional recognition you have been	PBELL id 0.0000 Basis for Co id Basis for Co R-REVIEWED PUBLICATIONS cations to which you have contributed and en given.	No. of Years in Practice: # omplaint omplaint omplaint omplaint omplaint omplaint omplaint
VIII.	Details of claims paid for Dr. CAM Date Amount Pa PHYSICIAN HONORS & PEE Please enter any peer-reviewed public professional recognition you have been Awards, Honors TUDENTSHIP NATIONIAL RESERT	PBELL id 0.0000 Basis for Co id Basis for Co R-REVIEWED PUBLICATIONS cations to which you have contributed and en given.	No. of Years in Practice: # complaint complai
VIII.	Details of claims paid for Dr. CAM Date Amount Pa PHYSICIAN HONORS & PEE Please enter any peer-reviewed public professional recognition you have been	PBELL id 0.0000 Basis for Co id Basis for Co R-REVIEWED PUBLICATIONS cations to which you have contributed and en given.	No. of Years in Practice: # complaint complai
VIII.	Details of claims paid for Dr. CAM Date Amount Pa PHYSICIAN HONORS & PEE Please enter any peer-reviewed public professional recognition you have been Awards, Honors TUDENTSHIP NATIONIAL RESERT	PBELL id 0.0000 Basis for Co id Basis for Co R-REVIEWED PUBLICATIONS cations to which you have contributed and en given.	No. of Years in Practice: # complaint complai
VIII.	Details of claims paid for Dr. CAM Date Amount Pa PHYSICIAN HONORS & PEE Please enter any peer-reviewed public professional recognition you have been Awards, Honors TUDENTSHIP NATIONIAL RESERT	PBELL id 0.0000 Basis for Co id Basis for Co R-REVIEWED PUBLICATIONS cations to which you have contributed and en given.	No. of Years in Practice: # complaint complai

Atlantic Associates, Inc., 8030 South Willow Street, Manchester, NH 03103

Board of Registration in Medicine

Physician Profile

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 Reg 60491 ACTIVE \$250.00 04	newal Date Late Fee / 28/93 \$25.00		Correction of Mailing Address:
Mailing Address:	7 2 0 7 7 3 9 2 0 1 0 0	Address (Mailing):	
ALAIN LESTER CAMPBELL, M.	D.	City/Town:	
		State:	
		Country Code (See	Table 1):
Directions: Staple check to bottom of form. Ac • Questions 1-8 include information from Board file provided on the right hand side of the page. • Before proceeding, please read the instruction boo • Make a copy of this form and all attachments f	es. Please correct as nec oklet. Some questions ar	essary in the boxes to optional.	For Office Use Only MR APR 2.7 1993 Pr APR 2.7 1993
for credentialing and other purposes. The Board • Enclose the \$250.00 renewal fee by means of a ce payable to the Commonwealth of Massachuseus.	will charge a fee for eac mified check, money ord	h copy it provides.	7776751777
Pre-Printed Information		Corre	ctions of Pre-Printed Information
1. Other name(s), if any, under which you were licer	nsed:		
2. a) Address (Home):		Address (Home):	Zip:
b) Address (Business): ATLANTICARE OB/GYN 493 WESTERN AVENUE LYNN, MA 01904		Country Code: Address (Business): City/Town:	If 999 print Country:
3. Date of Birth: Sex: 14 Lic. Issue Date: 10/19/88 SS#: Telephone Number: Home Business (517) 592-30		Lic. Issue Date (M/L relephone Number: Home: ()	Y):
4. Name of Medical School: McSill University Faculty Medicine Year Graduated: 75 Degree: MD	1	Year Graduated:	Degree (MD/DO):
a) Other states where you are now licensed to prace b) States where you previously were licensed to prace			Querec
	Γ	Code	Hours per Week in Mass.
6. Specialty Code(s) (See Table 2):	.		
Ode Hours per Week in Mass. Od6 64 Obstetrics and	Gynecology	If OS, print specials	y:
0 7. a) If you are currently American Specialty Board (Code: CG Code:	Certified, enter Codes: ((See Table 3)	Code:
b) If you previously were American Specialty Boa please enter codes of prior certification: (See T Code: Code:		mger,	Code:
8. Drug License Number(s), if any: a) Federal (DE b) State (MA)	A)		Federal (DEA): State (MA):
 I have completed my CME requirements in the two You must fill out a separate Waiver Form. The wa CME requirements. Do not submit documentation 	iver must be granted by	the Board before you	

PRINT NAME AND NUMBER: Physician Last Name: <u>CAMPBELL</u> Registration Number: <u>6049</u>	1
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	
List Insurer: MED. MALP. JOINT UNCERW. ASS., MA.	OII
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: O B / X (AP) Facility Code: O C Z / X (AP) Facility Code:/(AP)	
Facility Code: O 134 / 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 C	
If 999, write name(s): Facility Code: Facility Code: Facility Code:	_
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? 21 hrs/wk in MA iii) How many hours per typical week are you currently involved in inpatient care in MA? 22 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	2
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 flied 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.	l
· 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:	



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

1991-1993 Phy	sician Registration Renewal Application
Registration No. Status Fee Renewal Date 60491 ACTIVE \$150 04/28/91 Dr. ALAIN LESTER CAMPBELL	M D
 Questions 1-7 include information from Board files. Please correct Before proceeding, please read the instruction booklet. Answer all non-optional questions completely. (The instructions of Make a copy of this form and all attachments for your own records \$3.00 plus postage for each copy furnished.) 	t it as necessary. Decify which questions are optional.) you must give health care facilities copies for credentialing purposes. The Board charges oney order or personal check made payable to the Commonwealth of Massachusetts. XX Inactive
Pre-Printed information	Corrections of Pre-Printed Information
Other Name(s), if any, under which you were licensed:	Name:
2. a) Address (Home):	Address:City/Town
2.b) Address (Business): ATLANTICARE OB/GYN 493 WESTERN AVENUE LYNN, MA 01904-	Country Code:(If 999 write Country): Address: City/Town: State: Zip: Country Code:(If 999, write Country):
3. Date of Birth: Lic. tssue Date: 10/19/88 SSN #: Telephone Number: Home Business (617) 592-3000	Date of Birth (M/D/Y):
 Medical School Code: QUOD1 Year Graduated: 76 Degree Name of School: Faculty of Medicine, McGill Univ 	If GOOGG write School:
5. a) Other States where you are now licensed to practice (Abbr):	none uebec, Canada
8. Specialty Code(s) (See Table 3): Code Hours per Week in Mass. 03G 0 Obstetrics and Gyn. 0	e cology If OS, write specialty:
7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If Code: OG Board of Obstetrics ar Code:	YES, Enter Codes: nd Gynecology Code: Code:
B. Drug License Number(s) (if any) [optional]: a) Federal (DEA)	b) How many DEA nos, do you have? 1
 I have completed my C.M.E. requirements in the two years precedil (You must fill out a separate Waiver Form. The waiver must be gra- requirements. Do not submit documentation of your CME's with yo 	nted by the Board before your license will be renewed \ See Instructions for CME
30M - 9/90 - P813971	[For Office Use Only: Waiver Granted Date:/]

1.1	TLL IN NAME AND NUMBER; Physician Last Name: CAMPBELL ALAIN LESTER Registration No.: 60491	Q -
10	0. My medical malpractice insurance is covered by (a) INSURANCE CARRIER XX or (b) LETTER OF CREDIT	check one.
	Listinsurer: 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 (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: (ii) OTHERWISE EXEMPT:	am (Check one)
	(State how otherwise exampt):	
11	1. Current Hospital Affiliations (Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting private the codes from the codes f	dieges (AP).
	Facility Code: 008 KNAP) Facility Code:/_(AP) Facility Code:/_(AP)	
	Facility Code: 014 An(AP) Facility Code:/_(AP) Facility Code:/_(AP)	
	If 999, write Name(s):	
	Additional Hospitals at which you <u>previously</u> held privileges and other Health Care Facilities with which you were associated in the past 4 y (See Table 5.)	eart.
	Facility Code: 998 Facility Code: Facility Code: Facility Code:	
	# 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 ii) Residentii) Clinical Fellow or iii) Research Fellow? (Check one.) o) How many hours per typical week do you spend in this MA post-graduate training program?hrs./wk, in MA.	
40		
13.	. Care of Patients in Massachusetts (MA) (<u>See</u> instruction bookiet.) a) How many hours per typical week are you currently involved in <i>outpatient</i> 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	
	and the second of the second o	
Ref	setions 15 through 22 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 For fer to the instruction booklet for additional information.	
	fer to the instruction booklet for additional information.	m 15A. (91 No
15.	fer to the instruction booklet for additional information.	
15. 16. 17.	fer to the instruction booklet for additional information. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?	
15. 16. 17.	fer to the instruction booklet for additional information. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filled in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	
15. 16. 17.	fer to the instruction booklet for additional information. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?	
15. 16. 17. 18.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	
15. 18. 17. 18.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic oriense? 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)? Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason?	
15. 16. 17. 18. 19. 20.	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense? 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)? 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?	
15. 16. 17. 18. 19. 20. 21.	Has any pending or new medical malpractice claim been made against you (whether or not a lewsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?	es No
15. 16. 17. 18. 19. 20. 21. Puntex	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?	Ces No.
15. 16. 17. 18. 19. 20. 21. Punter 1000	Has any pending or new medical malpractice claim been made against you (whether or not a lawsult was filed in relation to the claim? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense? 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)? Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you had any mental lilness which has impaired your ability to practice medicine or to function as a student of medicine? Have you had an organic lilness which has impaired your ability to practice medicine or to function as a student of medicine? Are you now, or have you been in the past four years, dependent upon alcohol or drugs? Frauant 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 reason to M.G.L. c.82C asc.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massar returns and paid any Massachusetts state taxes, that are required under taxe. NOTE: This applies even if you realde out-of-etat	Ces No.
15. 16. 17. 18. 19. 20. 21. 22. Puritax	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filled in relation to the claim)? Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filled in relation to the claim)? 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)? Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency? Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	Ces No.
15. 16. 17. 18. 19. 20. 21. 22. Puritax	Has any pending or new medical malpractice cialm been made against you (whether or not a lewsuit was filed in relation to the claim? Have you been a defendant in any pending or new oriminal proceeding other than a minor traffic offense?	ervices.
15. 16. 17. 18. 19. 20. 21. 21. Purities i	Has any pending or new medical malpractice claim been made against you (whether or not a lawault was filed in relation to the claim)? Has any pending or new medical malpractice claim been made against you (whether or not a lawault was filed in relation to the claim)? 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 loc-qi)?	ervices.



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)

Fixed 4/7/88	For O	ffice Use		Application # 404
Form of Fee		Certificate #	0491	Date of Issue/0//9/88
Name Alain Lester	CAMPBEI	TATEMENT LL Address	Date: March	11th, 1988.
Date of Birth	Last		Montreal,	Quebec, Canada.
Place of Birth St-Hyacinthe, Quebe	ec, Can	ada	H3R 2T	6
Pre-Medical Education	1		Medical Ec	lucation
School University of Montreal		School]	McGill Univ	ersity
Years Attended B.Sc : 1969-72 previously: B.A. (Univ. M.	tl, 196	Years Attend	led <u>1972-76</u>	. M.D. C.M.
		& Hospital App		
Place POSTGRADUATE EDUCATION: M. Sc	osition (Exp	eGill Vai	1972- Medicine -	Dates Endocrinology)
Residency program: OB/GYN	W. McGi	ll Univ	and Univ. M B/GYN , Fac	t1; 1977-80 Medicine and
Graduate Studies, Uni List all other states in which you have been fully lice QUEBEC, only, Canada, 77.	:nsed:	niversity	Hospitals;	1981-actual 1988;
Other names under which you have been licensed: List Specialty Boards by which you are certified:	none AMERIC	AN BOARD	OF OBSTETRI	CS AND GYNECOLOGY

I never took the landien L.M.CC or Fix & proms;

This application for full brance or hierare restricted to 0 B/670

Our Jam cartified by an American specially forward I have

made a commitment to form an ob/640 practice at Attenti Care

medical Center, in Lynn, Mason, on July 15t 1988, which is a

designated medically Inderseased ease in ob/640; they are relying

on me to begin treating fathers on July 15t 1988

OBuphund.

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

FOR OFFICE US	UNLY CONTRACT
Full License	Application
Pending	Approved
License #	

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.	Tuestine Hearthal
PERMANENT ADDRESS: -	-Justine Hospital
ADDRESS: 317	5 COTE SAINTE-CATHERINE,
ADDRESS IN (MA).	treal, Quehec, Canada. 3T 1C5
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.	YES NO
1. Has any medical malpractice claim ever been made aga you in the last ten years (whether or not a lawsuit was	inst
in relation to the claim)?	1.
2. Have you ever been denied the right to participate o	r enroll
in any system whereby a third party pays all or part of patient's bill?	ā 2.
3. Have you ever applied for licensure or to sit for an	
examination or taken an examination, under a different n 4. Have you ever been denied the privileges of taking or	ame? 3.
finishing an examination or been accused of cheating and	/or
improper conduct during an examination since your matric in college?	
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 limited or temporary, for any reason?	full, 6.
7. Have you ever had staff privileges, employment or ann	ointment
in a hospital or other health care institution, denied, a or revoked, or resigned from a medical staff in lieu of	ıyapended
disciplinary action?	7,
8. Are any formal disciplinary charges pending or has an	1 \$
disciplinary action been taken against you in the last te by any governmental authority, by any hospital or health	'n years Care
facility, or by any professional medical association	~u · u
(international, national, state, or local)? 9. Have you ever voluntarily surrendered a license to	6.
practice medicine or any healing art? The Board's regul	ations
define "disciplinary action." Please refer to 243 CMR 3, attached.	02,
10. Have you ever withdrawn an application for medical	9.
licensure, hospital priviledges or appointment, for any r	eason? 10.
11. Have you ever for any reason, lost American Specialt Board Certification?	y 11.
12. Have you been denied required recertification by one	or
more specialty boards? If yes, which one(s)? 13. Have you, at any time, been a defendant in any crimi:	12.
proceeding other than minor traffic offenses?	13.
14. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denie	a.
restricted, surrendered or have you been called before	
or warned by this state or any other jurisdiction including	
a federal agency at any time? 15. Have you ever had any emotional disturbance or mental	14. 1
illness which has impaired your ability to practice medici	ine
or to function as a student of medicine? lo. Have you ever had an organic illness which has impair	15. red
your ability to practice medicine or to function as a stud	dent
of medicine? 17. Are you now, or have you been in the past, dependent	16.
slcohol or drugs?	17.
18. Have you ever held a license in Massachusetts or any state or country? If yes, list other jurisdictions.	other
MOTE ON OUTSTIONS 15-17, The harm sheet hefelth at the second	18.
OTE ON QUESTIONS 15-17: The harm that befalls physicians and patients mpairment goes undetected and untreated by the medical profession is	devestating.
The Board wants impaired physicians treated in the early stages of imparteness that to the physician or patient occurs.	altment before
f you have answered "yes" to any of the shows avent 410	please explain on the
· * * * * * * * * * * * * * * * * * * *	anamama Tand 11 makada S
he Board's regulations, 243 CMR 1.00 through 3.00. To the meet the qualifications for Full Licensure in Massachuse	e best of my knowledge
	11
hereby certify under the penalty of perjury that all infi front and back) including attached sheets is true.	ormation on this form

IGNATURE: De Olburgh

DATE: March 11th 1988



Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2 Board Use Only: Renewal Date 04/28/89 Registration No. 60491 Status \$150 M.R. Pr. ALAIN LESTER CAMPBELL Bk. Ch. n F 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. ____(FIRST:)____ALAIN CAMPBELL 1. b) Other Name(s), if any, that you were ever licensed under: NOT APPLICABLE 2. a) Address (Malling): SAME AS ABOVE 2. b) Address (Home): SAME AS ABOVE ATLANTICARE OB/GYN 2. c) Address (Business):____ 493 WESTERN AVE. LYNN. MA. 01904 2. d) Telephone (Business): (617) 592 3000 Extension 2. e) Telephone (Home) (Optional): (_______ Social Security No. (Optional):/ 4. Sex: MALE X FEMALE___ 3. Date of Birth (MO/DA/YR):__ 6. a) Medical School Code (See Table 1): QUO 01 # 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): 15 Private Office 20 Partnership/Group Practice ...50_% 10 Hospital 35 Nursing Home 30 Mental Health Center .. 2.0_% 25 Clinic 45 Educational Institution 50 Medical Society % 45 Educational Medicals
% 60 Plant/Commercial Setting 40 HMC Facility 55 Government Facility 8. b) Mass. Lic. Issue Date B. Professional Activity (Circle and Indicate Percent(%) of Professional Time): (see your wall certificate) 20 Practice Involving Direct Patient Care 10 Resident or Fellow (MO/DA/YR): 1019/88 40 Medical Teaching 30 Administrative Activities 99 Other 50 Medical Research 9. Specialty Code (See Table 3): <u>Q B G</u> Percent of Practice Time: <u>10 0 %</u> Specialty Code: _____ Percent of Practice Time: ____ % If OS, specify: 10. a) Are you American Specialty Board Certified? (Y/N) Y 10. b) #YES, circle which Board(e): Board of Plastic Surgery Board of Nuclear Medicine Board of Allergy & Immunology Board of Preventive Medicine Board of Obstetrics & Gynecology Board of Anesthesiology Board of Ophthalmology Board of Psychiatry & Neurology Board of Colon & Rectal Surgery CRS Board of Radiology Board of Orthopedia Surgery OS Board of Dermatology D Board of Surgery Board of Otolaryngology Board of Emergency Medicine OT **EM** Board of Thoracic Surgery Board of Pathology Board of Family Practice FP Board of Urology PE Board of Pediatrics Board of Internal Medicine PMR Board of Physical Medicine & Rehabilitation Board of Neurological Surgery 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: ______ Facility Code: 008 10% Facility Code: _____% 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: ____ Facility Code: ____ MONTRAL: HOTEL-DIEN UNIVERSITY HOSPITAL I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts. Pursuant to M.G.L. e475, 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.52C sec.49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed any Massachusetts state taxes 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—le true.

May 1989

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application,	Page 2 of 2	
Fill in name and number. Physician Last Name: CAMPRELL	Registration No.:	60491
12. a) Other States where you are now illoensed to practice (Abbreviate): S QU		
12. b) States where you previously were licensed to practice (Abbreviate):		
13. I am applying to be registered with the following status: ACTIVE_XX *INACTIVE_# HACTIVE, ans	war questions 14. a) (nawer question 14. b)	hrough c). only.
14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: <i>(Fill in # of hours or ty</i> Category I: 40 hrs., Category II: 60 hrs., (Risk-Management: 10 hrs.); Residency Program In: Walver Requested (You must fill out a separate Walver Form.)	pe of residency, or cl	neck walver.)
14. b) My medical malpractice insurance is covered by INSURANCE CARRIER.— LETTER OF CREDIT If applicable, che insurer: MED MAP. DINT UNIFRE 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 insura NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE. OTHERWISE EXEMPTED (State how)	ince because I am (C	heck one)
14. c) Percent of Practice Time in Massachusetts: 100 %		
Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on	Form 15A, attached.	'es <u>No</u>
15. Has any pending or new medical majoractice 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 oriminal proceeding other than a minor traffic offense?	Jet	
 Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations—See instruction against you by any governmental authority, hospital or other health care facility, or professional medical association (international, state or local)? 	e) been taken kilonal,	
위 you answered "YES" to question 15, 15, or 17 provide details on Form 15A, attached.		
***************************************	*********	****
Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in t	he next section. Y	es No
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, su have you been called before or been wamed by this state or any other jurisdiction including a federal agency?	rrendered, or	
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	7	
21. Have you had an organic litness 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	FOR OFFICE USE ONLY		
BOARD OF REGISTRATION IN MEDICINE	Specialty License Application		
SUPPLEMENT TO APPLICATION FOR	Pending Approved		
AMERICAN SPECIALTY BOARD	License #		
TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.		 -	
NAME: CAMPBELL DR ALAIN L.	110 hours		
PERMANENT ADDRESS:	HOSPITAL:		
	ADDRESS:		
LOCAL MAILING: CEA		***************************************	
Ol/or a	Applying on the basis of which		
ADDRESS IN (MA):	approved American Specialty Board? 95/6YN	····	
	Certificate Category?		
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.		VEC	МО
1. Has any medical malpractice claim ever been made against you in	the last ten years (whether or not a lawsuit	YES	NO
was filed in relation to the claim)?	And the family of the wilders		
2. Have you ever been denied the right to participate or enroll in any s	system whereby a third party page all or		
part of a patient's bill?	your of the party party pays an of		
3. Have you ever applied for licensure or to sit for an examination or to	aken an examination, under a different name?		
4. Have you ever been denied the privileges of taking or finishing an e	examination or been accused of cheating and /or		
improper conduct during an examination since your matriculation in	n college?		-
5. Have you ever falled any of the following examinations: the FLEX ex			
National Boards or failed to gain certification from the National Boards	rd of Medical Eversioers?		
6. Have you ever falled a foreign licensing or certification examination?			
7. Have you ever falled an American Specialty Board examination?	•		
8. Have you ever been denied a medical license, whether full, limited of	Of temperature for only recently		
9. Have you ever had staff privileges, employment or appointment in a	b hospital or other health age footbuilten		
denied, suspended or revoked, or resigned from a medical staff in it	r to white of other poemic case to standou		
Are any formal disciplinary charges pending or has any disciplinary			
last ten years by any governmental authority, by any hospital or he	y action peen taken against you in the		
medical association (international, national, state or local)?	arm care factory, or by any professional		
11. Have you ever voluntarily surrendered a license to practice medicine	e or any heating art? The Board's		
regulations define "disciplinary action." Please refer to 243 CMR 3.			
12. Have you ever withdrawn an application for medical licensure, hosp			
13. Have you ever, for any reason, lost American Specialty Board Certifi	cation?		
14. Have you been denied required recertification by one or more speci-			
15. Have you, at any time, been a defendant in any criminal proceeding	other than minor traffic offenses?		
 Has your privilege to possess, dispense or prescribe controlled subs restricted or surrendered, or have you been called before or warned 	Minces ever been suspended, revoked, denied,		
jurisdiction including a federal agency at any time?	Dy this state or any other		
 Have you ever had any emotional disturbance or mental illness which 	the base Connectional control (1994). In case of the control (1994)		
or to function as a student of medicine?	m has impaired your ability to practice medicine		
Have you ever had an organic illness which has impaired your ability	t de describes describes au de describes en e		
student of medicine?	A to blactice litericine of to innotion as a		
 Are you now, or have you been in the past, dependent upon alcohol. 	as down 0		
20. Have you ever held a license in Massachusetta or any other state or o			
QUEDEC # 77-182	country? If yes, list other jurisdictions,		
NOTE ON QUESTIONS 17-19: The harm that befalls physicians and pati	ente alike urban impairment eace undetected and use used		
by the medical profession is devastating. The Board wants impaired phy	ente anno when his the early steem of imprisoned and uniteated		
pefore ineparable harm to the physician or patient occurs.	rowant deated in the early stages of impailment		
f you have answered "yes" to any of the above except #20 please explain	n on the residence olds. Attach additional of the are to		
гресовавату.	TO THE TOYOLD SIGN. MINICH ENDINOUS N. 1. 1. STORES		
will read the Board's regulations, 243 CMR 1.00 through 3.00. To the be	ant of much hopping of mark the ministration		
or American Specialty Board Licensure in Massachusetts.	er of this kunamende titleet the drafilications		
	Hand and heath to the		
hereby certify under the penalty of perjury that all information on this for	rm (from and dack) including attached sheets is true.		
SIGNATURE: New John DATE:	1244 1488		
DATE	July 12th, 1988		
V	. 0		



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)

11/2/18			.or - No currency	or personal checks)
Fired: 4/7/80	For C	ffice Use		1,1710
Form of Fee CR			1.101	Application # 6404
Please Print	-	Certificate	*6047/	Date of Issue 10/19/88
,		TATEMEN	1	11th, 1988.
Name Alain Lester	CAMPBE			1 11th, 1988.
	Lasi	Address _		The state of the s
Date of Birth			-	- •
Place of Birth St-Hyacinthe, Quel	oec, Can	ada	H3R 2T	6
Pre-Medical Education			Medical E	ducation
School University of Montreal		School	McGill Univ	
B.Sc. : 1969-72	1			
Years Attended	Mtl, 196	Years Atte	nded <u>1972-76</u>	: M.D. C.M.
Postgradua	te Education d	Hospital A	and streets	
				Dates
POSTGRADUATE EDUCATION: M.S	c. (Expe	Gill Un	iv †975 T Medicine -	Endocrinology)
Residency program: OB/GY				
Appointments: Assistant	Prof C1	inical (OB/GYN . Fac	Medicine and
Graduate Studies, Un List all other states in which you have been fully lic	iv. Mont	7-7	The state of the s	
QUEBEC, only, Canada, 77	<u>'-</u> 182			1001 400441 1,000,
Other names under which you have been licensed:				
list Specialty Boards by which you are certified:	AMERICA	N BOARD	OF OBSTETRI	CS AND GYNECOLOGY

I never took the landian L.M.CC. or FEEX proms;
This application full because or hierce restricted to 0 B/67N
Our dam cartified by an American specialty forced I have
made a community form an ob/64N practice at Attentione
Medical Center, in Lynn, Mass., on July 157 1988, which is a
descripted Medically Inderserved are in 0 B/64N ; they are relying
on me to begin teating Jutuals on July 157 1988

OBWHULME.

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Alain L. CAMPBELL HOSPITAL: Ste-Justine Hospital NAME: Alain L. CAMPBELL PERMANENT ADDRESS:

ADDRESS: 3175 COTE SAINTE-CATHERINE, Montreal Quebec Canada

LOCAL MAILING ADDRESS IN (MA):

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW. YES NO 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? 2. 3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name? 3. Have you ever been denied the privileges of taking or finishing an examination or been accused of chesting and/or improper conduct during an examination since your matriculation in college? 4. Have your ever failed an examination (including the FLEX Examination) before any state or the National Boards? Have you ever been denied a medical license, whether full, limited or temporary, for any reason? 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. B. 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? 12. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)?
13. Have you, at any time, been a defendant in any criminal 12. 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 14. a federal agency at any time? 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? 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,

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: DR. Olbuphla DATE: March 11th

to: Table

Physician Name: ALAIN LESTER CAMPBELL License No.: 60491

PART A				
1) Current Status: Active Renewal Du	ue Date: 03/31/2005 Birth Date:			
If you want to change your current status, please of	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, pa	age 3.) ☐ Inactive ☐ Do not wish to renew			
☐ Active ☐ Retiring	Li inactive Li Do not wish to renew			
2) Addresses & Contact Information. Please confirm yo required to notify the Board of Registration in Medicin Business addresses <u>CANNOT</u> be a Post Office Box.	rour addresses and make changes, if necessary. You are ne within 30 days of any change of address. Home and Picase make corrections (print)			
2a) MAILING ADDRESS				
9 BOSTON STREET	Mailing Address:			
SUITE 9	City/Town: State:			
LYNN, MA 01904-0000	Zip: Country:			
Check here to change this address	Zip. County.			
THE RESIDENCE ADDRESS	Home Address:			
C.FT	City/Town: State:			
3 2	Zip: Country:			
Phone:	Home Telephone: ()			
Phone: Check here to change this address BUSINESS ADDRESS 9 BOSTON STREET	Home address cannot be a Post Office Box			
2c) BUSINESS ADDRESS				
9 BOSTON STREET	Business Address:			
SUITE 9	City/Town: State:			
LYNN, MA 01904-0000	Zip: Country:			
Phone: (781)592-3000	Business Telephone: ()			
Check here to change this address	Business address cannot be a Post Office Box			
3) E-mail Address: NOT AURICABLE 47	T OFFICE			
4) Fax Number: 781-592-9625				
5) Specialties (See Renewal Instructions, page 4.)	Delete? Additional specialties:			
Obstetrics and Gynecology				
Market 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0			
6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Information. (See enclosed instructions and Renewal Instructions, page 4.)				
List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.			
Board Name ABMS or AOA	Certificate/Subspecialty Correct? Delete?			
AMERICAN BORRO OBSTETRICS GYNEGLOGY & -	Obstetrics & Gynecology			
0 0				

Physician Name: ALAIN LESTER CAMPBELL (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.) MONE a) Massachusetts: 8b) States where you were previously licensed (Abbr.) b) Federal (DEA): c) Federal (DEA) XS: QUE BEC 9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Private Office 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 Staff Category # Hours Health Care Facility (See Renewal Instructions, page 4.) Delete? per Week Current Change North Shore Medical Center - Salem Hospital Admitting 0.5 Union Hospital Admitting 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Change to: ____ hrs/wk 5 hrs/wk Average weekly hours involved in: a) inpatient care Change to: 18-19 hrs/wk 30 hrs/wk b) outpatient care _ 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 /- 3/02 2 Change to: From 02/07/05 To 02/07/06 Policy dates: (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:

☐ Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt (Please explain):

Page 2 of 5

Check one:

Pos

Physician Name: ALAIN LESTER CAMPBELL License No.: 60491

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

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

 $||\mathbf{j}_{n}\mathbf{l}_{n}^{(n)}||$

You must check either YES or NO to each question. Provide details on <u>Form R</u> 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: X Yes No a) Have you completed your CME requirements preceding your renewal date? 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.) ☐ Residency/Fellowship training

Physician Name: ALAIN LESTER CAMPBELL License No.: 60491

PHYSICIAN PROFILE

图	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.

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

6.99



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

Physician Registration Renewal Application

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need copies for crede green envelope at lease •Remit \$400.00 •Add late fee o	ntialing and other s <u>t 4 weeks</u> before y for renewal fee (1 f \$25.00, if necess;	purpose This comple your renewal taste. APR non-refundable.	ted renewal form with attachments for your own records; you will ted renewal form with attachments must be returned in the 1 2003 Return renewal application in GREEN envelope. • Enclose check with coupon in BLUE envelope.
			ed or your renewal will be delayed.
1. Current Status: A	active	Registration No. 6049	Renewal Date: 04/28/2003
If you want to change	your current status,	please check one of the fe	ollowing boxes to indicate your new status: (Check only one)
Active :	Retiring (see instr	uctions) Inac	tive (see instructions)
2. Other Name(s), if an	ıy, under which you	ı were licensed:	Please make corrections (print)
A) Mailing/Busines 3. ALAIN LESTER 9 BOSTON STER SUITE 9 LYNN, MA 019 B) Home Address:	R CAMPBELL REET		Other Name(s) Name Change (enter name below) Mailing Address: City/Town: State: Zip: Country:
			Business Address: City/Town: Zip: State: Business Telephone: (781) 592-3000 Home Address:
Home Phone: Business Phone:			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.
a) Date of Birth:	b) Sex:		American Board of Medical Specialties Certification (See Table 2)
c) SS#:	1	M Code:	Code: ense Numbers, if any:
a) Name of Medical Sch b) Year Graduated:		a) Fede b) Mas	eral (DEA): esachusetts: er states where you are now licensed to practice (Abbr.) **ABE
		b) Star	es where you were previously licensed (Abbr.)
care. (Supply the codes:	from <u>Table 3</u> and p	lace a check mark next to	nave completed the credentialing process for the provision of patient those health care facilities where you have admitting privileges (AP) hours that you provide in each facility) No affiliations.
Facility Code: 537/4 Facility Code:/_ f 999, print name(s):	(AP) <u>5</u> %	Facility Code: 538/4 Facility Code:/	(AP) /0 % Facility Code: / (AP) % (AP) % Facility Code: / (AP) %

PRINT YOUR LAST NAME:	CAMPBELL	LICENSE NUMBI	er: 60491 -	16.
11. My medical malpractice insurance	1		_	
	MUTUAL: 1-3/022 PC		4/03 To: 02/07/0	4
Alternatively, indicate as follows:	I am registering with Active status tot involved in direct/indirect patient	but I am not covered by medi-	cal malpractice insurance	:
Otherwise exempt Please expl	ain exemption:			
12. What is your principal work setting for the provision of patient care you	g? (See <u>Table 4</u>) / <u>5</u> If you must complete <u>question #10</u> on page	ou are affiliated with a health ge 1 and list your affiliations.	icare facility or credential	ed
13. Care of patients in Massachusetts	(see instruction booklet).			
	oved in: A) inpatient care5_1	rs/wk B) outpatient care	30 hrs/wk	
	ercentage of your patient care hours i			
PART A - QUESTIONS REF	ER ONLY TO THE PAST T	WO (2) YEARS (SEE I	(NSTRUCTIONS)	
Questions 14 through 22 refer to the question. Provide details on Form R and definitions. ALL questions in the your renewal.	for all YES answers (except quest	ion 22). Refer to instruction	ns for additional inform:	ation
			YES	NO
15. <u>CLAIMS (Resolved):</u> Has any adjudicated, or otherwise resolved 16. Has any lawsuit, other than a medi	nted, whether or not a lawsuit was file medical malpractice claim that has be whether or not a lawsuit was filed in	ed in relation to the claim? een made against you been set n relation to the claim? I to your competency to practi	ttled,	·
17. Have you been charged with any c	niminal offense?			ı
18. Have you been charged with or dis	1	iles, by-laws or standards of p essional society or association	ractice of	
 Has your privilege to possess, disp restricted by, or surrendered to any 		es been suspended, revoked,	denied,	
20. Have you withdrawn an applicatio				i
	on related to professional competency or terminated your insurance coverage	y or conduct on your coverage	e, or have	
22. CME CERTIFICATION: Have	you completed your CME requireme	nts preceding your renewal de	ate? Yes No	
	orm must be submitted at least 30 day			
CME EXEMPTION: Check one	Inactive status Resi	dency/Fellowship training (Se	ee instructions).	
See Instructions for CME waiver	or exemptions. Do not submit do	cumentation of your CMEs	with application.	
and the punishment for failure	A, I understand my obligations to rep to comply. I will not charge to or collect from			
 Pursuant to G.L. c. 62C, 49A, Massachusetts state tax returns 	I certify that I have complied with all and payment of all Massachusetts st and remitting child support pursuant	ate taxes; reporting of employ	yees and contractors unde	г
I hereby certify under the penalties	of perjury that all information on	this Renewal Application, P	art B and Form R is tru	1e.
Signature:	Hursell	and the state of t	Date: 04 107 16	23
YOU MUST SIGN AN	D INCLUDE PART B. WIT	H YOUR RENEWAL A	APPLICATION	

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



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

Physician Registration Renewal Application

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need copies for cr	g, <i>please read the instruction</i> redentialing and other purpose <i>least 4 weeks</i> before your rene	Duis comple	vithis form and all-ethehments for your own records; you will ted renewal form with attachments must be returned in the
•Add late fo	0.00 for renewal fee (non-refu ee of \$25.00, if necessary.	dable).	1 1 2003 • Return renewal application in GREEN envelope. • Enclose check with coupon in BLUE envelope.
Please review alterations as	carefully the following in required. <u>All questions</u> mi	formation far ist be answer	coard of and completeness. Make any corrections or ed or your renewal will be delayed.
1. Current Status:	Active Regist	ration No. 60491	Renewal Date: 04/28/2003
If you want to chan	ige your current status, please ch	eck <u>one</u> of the fo	ollowing boxes to indicate your <u>new</u> status: (Check only one)
☐ Active	Retiring (see instructions)	☐ Inac	tive (see instructions)
2. Other Name(s), i	if any, under which you were lice	ensed;	Please make corrections (print)
A) Mailing/Business Address: 3. ALAIN LESTER CAMPBELL 9 BOSTON STREET SUITE 9 LYNN, MA 01904-0000			Other Name(s) Name Change (enter name below) Mailing Address: City/Town: State:
B) Home Addre			Zip: Country: Business Address:
Home Phone: Business Phone:			Home Address: City/Town: Zip: Country: Home Telephone: PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.
. a) Date of Birth:	b) Sex:	7. Current .	American Board of Medical Specialties Certification (See <u>Table 2</u>) Code:
c) SS#: a) Name of Medical S b) Year Graduated: Specialty Code(s) (See	School: ty Faculty of Medicine 1976 C. Degree M.D.	8.Drug Lice a) Fede b) Mas	ense Numbers, if any: eral (DEA): esachusetts: er states where you are now licensed to practice (Abbr.) NON E
	Obstetrics and Gynecology		es where you were previously licensed (Abbr.)
care. (Supply the cod	les from Table 3 and place a che	ck mark next to	have completed the credentialing process for the provision of patient those health care facilities where you have admitting privileges (AP nours that you provide in each facility) No affiliations.
Facility Code: 537 Facility Code: If 999, print name(s):	/ (AP) 5 % Facility C	Code: 538/4 Code:/	(AP)

PR	INT YOUR LAST NAME:	CAMPBELL	LICE	NSE NUMBER:	6049	<u> </u>	&
	My medical malpractice insurance			er of Credit			
	Insurer's name. (Required): PRO-			n: 02/07/0	3 To: 02	4071	04
	Alternatively, indicate as follows: because I am: Check One: N	I am registering with Active	status but I am not cov	ered by medical i	malpractice	insuranc	ce
	Otherwise exempt Please expla	in exemption:					
12.	What is your principal work setting for the provision of patient care yo	g? (See <u>Table 4</u>) / <u>5</u> u must complete <u>question #1</u>	If you are affiliated on page 1 and list you	with a healthcare r affiliations.	e facility or	credenti	aled
13.	Care of patients in Massachusetts (see instruction booklet).					
	1) Average weekly hours invo	lved in: A) inpatient care	5 hrs/wk B) outp	oatient care 36	hrs/wk		
	2) What is the approximate per	centage of your patient care	hours in primary care?	5 %			
PA	RT A - QUESTIONS REFE	ER ONLY TO THE PA	<u> IST TWO (2) YEA</u>	RS (SEE INS	TRUCT	(ONS)	
gue and	estions 14 through 22 refer to the stion. Provide details on Form R definitions. ALL questions in thir renewal.	for all YES answers (excer	t question 22). Refer t	o instructions fo	r addition:	<u>al inforn</u>	natio
						YES	NO
15.	CLAIMS MADE (New or Pendin yet been finally settled or adjudicat CLAIMS (Resolved): Has any nadjudicated, or otherwise resolved, Has any lawsuit, other than a medic or your professional conduct in the otherwise resolved?	ed, whether or not a lawsuit nedical malpractice claim the whether or not a lawsuit was al malpractice suit, which is	was filed in relation to that has been made against a filed in relation to the confered to your competer.	he claim? you been settled claim? ency to practice n	nedicine,		
17.	Have you been charged with any cr	iminal offense?					
18.	Have you been charged with or disc any governmental authority, health				ice of		
19.	Has your privilege to possess, disperestricted by, or surrendered to any		ubstances been suspend	ed, revoked, deni	ed,		
20.	Have you withdrawn an application	for a medical license or bee	n denied a medical licen	se for any reason	?		
	Has any professional liability insura co-payment, or placed any condition you voluntarily restricted, limited of professional liability insurance prov	n related to professional com r terminated your insurance	petency or conduct on y	our coverage, or	have		
22.	CME CERTIFICATION: Have y	ou completed your CME rea	quirements preceding yo	ur renewal date?	Yes	☐ No)
	☐ CME Waiver. CME waiver for	m must be submitted at leas	t 30 days prior to license	expiration date.			
	CME EXEMPTION: Check one:	☐ Inactive status] Residency/Fellowshi	p training (See in	structions).	ı	
	See Instructions for CME waiver	or exemptions. Do not sub	mit documentation of	your CMEs with	applicatio	n.	
	 Pursuant to G.L. c. 112, Sec 1A and the punishment for failure t Pursuant to G.L. c. 112, Sec. 2, 	o comply.					
	amount. Pursuant to G.L. c. 62C, 49A, I Massachusetts state tax returns G.L. c. 62E; and withholding an	certify that I have complied and payment of all Massach	with all laws of the Con usetts state taxes; reporti	nmonwealth relating of employees	ed to the fil and contrac	ling of	
I b	ereby certify under the penalties (f perjury that all informat	ion on this Renewal Ap	plication, Part	B and Forr	nR is tı	rue.
Sign	ature:	Curplel		. Di	ate: 04	0711	03
		L					

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



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

Page 1 of 5 Date: 4/26/2011 Time: 11:17 AM



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

Medical Professional Mutual Ins Co

Policy Start Date 02/07/2011

Policy End Date

Policy Type

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?



Physician Name: Alain Lester Campbell, M.D.

License No.: 60491

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)

Page 3 of 5 Date: 4/26/2011 Time: 11:17 AM



Physician Name: Alain Lester Campbell, M.D.

License No.: 60491

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?

Page 4 of 5 Date: 4/26/2011 Time: 11:17 AM



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)**! 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.
 - 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.
 - 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.

Page 5 of 5 Date: 4/26/2011 Time: 11:17 AM



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

Page 1 of 5 Date: 4/30/2013 Time: 12:37 PM



License No.: 60491

Physician Name: Alain Lester Campbell, M.D.

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?

Page 2 of 5 Date: 4/30/2013 Time: 12:37 PM



Commonwealth of Massachusetts Board of Registration in Medicine Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D.

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

License No.: 60491

Page 3 of 5 Date: 4/30/2013 Time: 12:37 PM



Commonwealth of Massachusetts Board of Registration in Medicine Physician Renewal Application

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

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?

Page 4 of 5 Date: 4/30/2013 Time: 12:37 PM



Commonwealth of Massachusetts Board of Registration in Medicine Physician Renewal Application

License No.: 60491

Physician Name: Alain Lester Campbell, M.D.

Compliance with Legal Responsibilities

Online profile:

XI have reviewed my Physician Profile and confirm that the information is accurate

- 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) 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)! 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.
 - 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.
 - 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.

Page 5 of 5 Date: 4/30/2013 Time: 12:37 PM

Data Date Number: 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, 20
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 v 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 applied for an NPI using a third party (enter name):
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 y authorize BORIM to apply for an NPI on your behalf.
Taxonomy (Specialty) Code Taxonomy Description (Print)
Primary Provider Taxonomy: 207V0000X Obstetre CS & 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): CANADA Country of Birth (if outside the US): CANADA
Gender: Male
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 year 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 gas 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: Man Holl Date: 02/11/2007



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, 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

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 <u>one</u> of the following boxes to indicate your <u>new</u> status: Check only one: (See Renewal Instructions, page 3.) ☐ Active ☐ Retiring ☐ Inactive Do not wish to renew 2) Addresses & Contact Information. Please confirm your addresses and make changes, if necessary. You are required to notify the Board of Registration in Medicine within 30 days of any change of address. Home and Business addresses **CANNOT** be a Post Office Box. Please make corrections (print) 2a) MAILING ADDRESS 9 Boston Street APR 1 0 2007 Mailing Address: Suite 9 City/Town: State: Lynn, MA 01904-0000 Country: ☐ Check here to change this address **2b) HOME ADDRESS** Home Address: City/Town: Country: Home Telephone: (___)____ Phone: Check here to change this address Home address cannot be a Post Office Box 2c) BUSINESS ADDRESS Business Address: 9 Boston Street Suite 9 City/Town: State: Lynn, MA 01904-0000 Country: Business Telephone: Phone: (781)592-3000 Check here to change this address Business address cannot be a Post Office Box Correct your E-mail and Fax Number below: 3) E-mail Address: 4) Fax Number: 781-592-9625 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.) Update General Certificates and Subspecialty Certificates List Certifying Board(s) below: below. Please add additional Certifications as required. Board Name ABMS or AOA Certificate/Subspecialty Delete? Obstetrics & Gynecology **ABMS** Obstetrics and Gynecology

Page 1 of 9

1))

5/3

. Massachusetts	Physician	Renewal Applica	tion		
Physician Name: Alain Lester Campbell,	M.D.		60491		
(See Renewal Instructions, page 4.) 7) Drug License Numbers Correc a) Massachusetts: b) Federal (DEA): c) Federal (DEA) XS:	tions:	Please make corrections as ne 8) Other states where you ar 9) States where you were pre	e <u>now</u> licensed		
10) List all work sites in Massachusetts, in offices, clinics, nursing homes, etc. For the page 18 of the Renewal Instruction bookle or companies. Please provide all information	e names of the le et. Include any ion on all work	ealth care facilities, refer to affiliations with Internet-ba	Reference Ta	able 4 on	
List the names of all work sites in Massachusett (See above and description on page 4.)	s	Location (City or Town)	State	Delete?	
North Shore Medical Center - Salem Hospital			mA		
Union Hospital		SAZEM	MA		
		1334			
11) Care of nations in Massachusetts /Sac Barre			***************************************		
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 (Se	e Renewal Instruc	tions, page 5.)			
Check one. Locum tenens must list policy dates			gh:		
Insurance Carrier (complete below)		•			
Current Insurance Carrier: ProMutual Grou	,	Change to:			
Policy dates: From #2/07/3007	To 02 107 12	008			
Type of Policy: Claims made with tai (Enclose a copy of the c	-	Occurrence Policy rance or the face sheet)			
Letter of Credit subject to Board approval	l (Attach a copy.)				
☐ I am registering with Active status but I a	m not required to	have medical liability insuran	es basanca Lam		
Check one:	ect or indirect pati yee under Federal	ent care in Massachusetts Tort Claims Act (FTCA)		1:	
13) Do you perform any surgery in your Massac	husetts office? (S	ee Renewal Instructions, page 5.,) Yes	No	

If $\underline{\text{Yes}}$, please complete Form PCA-O "Office Based Surgery" Form on page 8.

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.

	IES 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?	j
c) Are there any criminal charges pending against you today?	İ
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?	İ
b) If no, are you requesting a CME waiver?	}
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 1	Renewal Application
	Physician Name: Alain Lester Campbell, M.D.	License No.: 60491
PAR'	<u>1 C</u>	NO.
Che	eck One: PHYSICIAN PROF	•
12	I have reviewed my Physician Profile at http://profiles.massm (Please note that if you changed or corrected your business ad certification and/or hospital affiliations on your renewal applied.	dress, business phone number practice specialty board
	I have reviewed my Physician Profile and attached a copy of t	he Profile with corrections.
	My status is Inactive and I do not have a Physician Profile. (Se	ee Renewal Instructions, page 11.)
	CERTIFICATION	<u>NS</u>
1) I o unde	certify that I have complied with my obligations to report abuse or erstand the punishment for failure to comply.	or neglect of children pursuant to G.L. c. 119, sec. 51A, and 1
2) 1 o	certify that I have complied with my obligations to report abuse of derstand the punishment for failure to comply.	or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and
3) I o G.L.	certify that I have complied with my obligations to report abuse, a c.19A, sec. 15, and I understand the punishment for failure to co	neglect or financial exploitation of elderly persons pursuant to mply.
4) I c sec. 1	certify that I have complied with my obligations to report the trea 12A.	tment of wounds, burns and other injuries pursuant to G.L. c. 112,
5) I c sec. I	certify that I have complied with my obligations to report the treat 12A 1/2.	tment of victims of rape or sexual assault pursuant to G.L. c. 112,
6) l c when	ertify that I have complied with my obligations to report a physic I have a reasonable basis to believe that person violated any pro	cian to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, visions of G.L. c. 112, sec. 5 or any Board regulation.
7) I cowith t	ertify that I have complied with my obligations related to chargin he Medicare fee schedule, and I understand my obligations unde	g and collecting fees from Medicare beneficiaries in accordance r G.L. c. 112, sec. 2.
8) I co that, p perjur	ertify that I have complied with my obligations to file Massachus pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued by.	etts tax returns and to pay Massachusetts taxes, and I understand or renewed unless I make these certifications under penalties of
9) I ce	ertify that I have complied with my obligations related to the repo	orting of employees and contractors pursuant to G.L. 62E.
10) 1 (certify that I have complied with my obligations related to the wit	hholding and remitting of child support pursuant to G.L. c.119A.
buvan	certify that I have complied with my obligations to file an Incident of office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assestient Care Assessment (PCA) programs at the health care facilities	ssment Regulations 243 C M R 3 00 et sea Lunderstand that
12) I c legal e	ertify that I have complied with my obligations to disclose my overtity to which I have referred a patient for physical therapy services.	vnership interest in any partnership, corporation, firm or other ces pursuant to G.L. c. 112, sec. 12AA.
hereit under	r penalties of perjury, I declare that I have examined actions, forms and statements, and to the best of my l in is true, correct, and complete. As an applicant for a rstand that a criminal record check may be conducte mation from the Criminal History Systems Board on	knowledge and belief, the information contained renewal of a license to practice medicine, I d for conviction and nending criminal case

Signature: Date: 03 / 33 / 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.

licensure.



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: ☐ 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 laxonomy code is required if you authorize BORIM to apply for an NPI on your behalf. Taxonomy (Specialty) Code Taxonomy Description (Print) Primary Provider Taxonomy: OBJETRICS- CYNECOLOGY 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): Male Gender: ☐ 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.

Date: 04/04/07

Physician Name: Alain Lester Campbel	ian Name: Alain Lester Campbell, M.D. License No.: 60491		91	
PART A	<u></u>			
	Donowal Tine Tate	: 03/31/2009 Birth Date	.•	
1) Current Status: Active Renewal Due Date: 03/31/2009 Birth Date: If you want to change your current status, please check <u>one</u> of the following boxes to indicate your <u>new</u> status:				
Check only one: (See Renewal Instr		ME Of the following boxes to indicate your	riorr outuo.	
☐ Active ☐ Retiring		ctive	enew	
2) Addresses & Contact Information. Please required to notify the Board of Registration	confirm your add	lresses and make changes, if necessary. in 20 days of any change of address. Ho	You are me and	
Business addresses <u>CANNOT</u> be a Post Office		Please make corrections (print)	ERV SAFA	
2a) MAILING ADDRESS	1			
9 Boston Street		Mailing Address:		
Suite 9		City/Town:		
Lynn, MA 01904-0000		Zip: Country:		
Check here to change this address		Zip: Country:		
2b) HOME ADDRESS				
LU) HOME ADDICUS		Home Address:		
		City/Town:	State:	
		Zip: Country:		
		Home Telephone: ()		
Phone:	-	Home address cannot be a Post O	ffice Box	
Check here to change this activess	2 2009		·	
20) BUSHNESS ADDRESS		Business Address:		
Suite O	Registration	City/Town:		
Lynn, MA 01904-0000	edicine	Zip: Country:		
		Business Telephone: ()		
Phone: (781)592-3000		Business address cannot be a Po	st Office Box	
Check here to change this address	Andrew Control	Correct your E-mail and Fax Number below:		
3) E-mail Address:			·	
4) Fax Number: 781-592-9625		Apareparameters of April - Print States		
5) Specialties (See Renewal Instructions, page	e 4.) Delete?	List Additional Specialties:		
, ,		List Additional Speciaties.		
Obstetrics and Gynecology				
ATT				
6) Current American Board of Medical Spe	ecialties (ABMS)	or American Osteopathic Association (A	OA) Information.	
(See enclosed instructions and Renewal Instru	ıctions, 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	A Certificate/Subspecialty Delete?		Delete?	
Obstetrics & Gynecology ABMS	Obstetrics and Gynecology			

Physician Name: Alain Lester Campbell, M.D.		License N	o.: 60491		
(See Renewal Instructions, page 4.) 7) Drug License Numbers Corrections: a) Massachusetts: b) Federal (DEA): c) Federal (DEA) XS:		Please make corrections as n 8) Other states where you a NH 9) States where you were pr	re <u>now</u> licensed		
10) List all work sites in Massachusetts, including health care facilities (where you are credentialed), private offices, clinics, nursing homes, etc. For the names of the health care facilities, refer to Reference Table 4 on page 18 of the Renewal Instruction booklet. Include any affiliations with Internet-based prescribing services or companies. Please provide all information on all work sites, attaching a separate sheet, if necessary.					
List the names of all work sites in Massachusetts (See above and description on page 4.)		Location (City or Town)	State	Delete?	
North Shore Medical Center - Salem Hospital					
Union Hospital					
				Bravil	
11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Average weekly hours involved in: a) inpatient care hrs/wk					
Type of Policy: Claims made with tail cove (Enclose a copy of the certific	medical lia	Change to: Change to: Occurrence Policy urance or the face sheet)	ough:		
Letter of Credit subject to Board approval (Atta	ich a copy.)			
☐ I am registering with Active status but I am not	t required	to have medical liability insur	ance because l	am:	
Check one: Not involved with direct or A Government Employee un Otherwise exempt (Please e	nder Feder				
13) Do you perform any surgery in your Massachuset If <u>Yes</u> , please complete Form PCA-O "Office Ba			5.) Yes	No	

04/23/09 81

8

Massachusetts Physician Renewal Application

Physician Name: Alain Lester Campbell, M.D.

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 <u>Form R</u> if you answer "YES" to any questions. Refer to Renewal Instructions for additional information and definitions.

YES NO

License No.: 60491

	125 110
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?	
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)	

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

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.
- 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

Ø	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.)
Una inst	ler penalties of perjury, I declare that I have examined this renewal application and all its accompan ructions, forms and statements, and to the best of my knowledge and belief, the information contains

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:	Murphic	Date:	03 127 1200	9
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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.