101592

Initial Medical Licensure
PERSONAL INFORMATION
08/2003 INT

STATE OF MARYLAND
BOARD OF PHYSICIANS

P.O. Box 37217 • Baltimore, MD 21297
Telephone: 410-764-4777 Fax: 410-358-2252 Toll Free: 800-492-6836

FOR BANK USE ONLY
Date
Check Number 299
Amt Paid 919.80
Name Code
AppID 17

APPLICATION FOR INITIAL MEDICAL LICENSURE

Please print legibly or type the required information. Do not leave any item unanswered. If an item does not apply to you, write "N/A" (Not Applicable) for that item. An incomplete application form will delay the processing of your application.

1. Your Complete Current Legal Name: As listed on your U.S. birth/marriage certificate, U.S. passport, or most recent document issued by the INS.

Last name and generational indicator (Jr., Sr., II, III, etc.): CHANG

First name and middle name: DAVID AUGUSTO

(If applicable, please check a box and complete below) ☐ Complete Maiden Name OR ☐ Complete Former Name

Stop! If any credential you submit bears a name other than your current legal name as listed above, or if you have been licensed in another state under any name other than your current legal name, sign and date an attachment which includes each different name, an explanation of why the name differs from your current legal name, and a copy of the legal document to support the name change.

2. Public Address: Your public address of record. This address, usually your office, is available to the public and will be posted on the internet.

Street Address: If you change your address prior to being licensed, immediately notify the Board in writing.
1035 N CALVERT ST 2A

City: BALTIMORE State: MD Zip Code: 21202-

3. Non-Public Address: This address, usually your home, is for Board use only. However, if no public address is listed, this address will be made public.
Street Address: (Do NOT use a P. O. Box) If you change your address prior to being licensed, immediately notify the Board in writing.

City State Zip Code -

MARYLAND BOARD OF PHYSICIANS RECEIVED 2008 FEB 15 AM 9 25

4. Telephone (s): Home - -

Office: 410-965-6710

Cell-pager:

E-mail address:

5. Date of Birth: Month Day Year

6. Gender: ☒ Male ☐ Female

7. Race: Multiracial applicants may select all applicable categories American Indian or Alaska Native Asian Black or African American Native Hawaiian or other Pacific Islander White

Ethnicity: ...anic or Latino ☐ Not Hispanic or Latino

8. Social Security Number:

Federal Employer Identification Number:

License Number:	D67401	BPQA School Code:	737006 A
Date Issued:	040808	Federation School Code:	737020
Licensed By: D. Rufus		Licensing Exam: USMLE	

Initial Medical Licensure CHRONOLOGY [illegible]

Print Your Name: DAVID A. CHANG Date: 01/23/08

Page 2

9. **Chronology of Activities: DO NOT ATTACH RESUME OR CURRICULUM VITAE**

Beginning with the date you completed medical school and continuing through the present, list chronologically all of your activities. Account for all periods of time including each post-graduate training program you attended, regardless of whether or not you completed the program; each job you held, regardless of whether or not it was medically related or you were compensated; and any period of unemployment.

Date Medical School was Completed:	month	year
	04	03

Activities after completing medical school: Please type or print.

month	year	TO	month	year	Activity / Address
05	03	TO	05	03	Activity: Volunteer Medical/Surgical Mission in PERU (with Peruvian American Medical Assoc.)
					Address:
05	03	TO	06	04	Activity: Medical Assistant at the GYN-OB Birth + Surgi Center. Lima, Peru.
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:
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					Address:
		TO			Activity:
					Address:
		TO			Activity:
					Address:

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CONTINUED ON PAGE 3: If you will need more space than page 3 allows, please photocopy page 3 for your use or attach a separate sheet. Please sign and date each sheet you attach.

Print Your Name: David A. CHANG Date: 01/23/08

Page 3

Chronology (Cont'd) Please photocopy this page if more space is needed. Sign and date all additional pages and enclose them between pages 2 and 3 of the application.

month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:
month	year	TO	month	year	Activity:
					Address:

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Initial Medical Licensure
MEDICAL EDUCATION
08/2003 INT

Print Your Name: DAVID A. CHANG Date: 01/23/08

10. MEDICAL EDUCATION: List all medical schools you have attended From: MM/YY To MM/YY

UNIVERSIDAD PERUANA CAYETANO HEREDIA 04/95 to 04/03

Medical School From Which You Received Your Medical Degree: UNIVERSIDAD PERUANA CAYETANO HEREDIA

Name of University Affiliation (if applicable): * UNIVERSIDAD PERUANA CAYETANO HEREDIA

Street Address: AV. HONORIO DELGADO 430 Urb. Ingenieria SMP

City: LIMA 31 **Country:** PERU **Country of citizenship during medical education:** USA / PERU

Language(s) of instruction: SPANISH

Type of Degree: ☒ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☐ Other: ________ (specify)

Date Degree Was Conferred: The date you officially received your degree after all prerequisite obligations, required training, government service, etc. was satisfied.

Month 04 Day 29 Year 03

[illegible] OF FOREIGN MEDICAL SCHOOLS (Schools not in the U.S. or its territories, Puerto Rico, or Canada) [illegible] the following documents to this application:

1) A copy of your valid ECFMG certificate or Fifth Pathway Certificate; (FCVS)

2) A copy of your medical school diploma and a certified translation; (REQUEST SENT).

[illegible] above (see * in 10 above), attach a copy of the Certificate of Medical Education and [illegible] Conduct Certificate or Intern Certificate. The certificate must include your name, name of the [illegible] of the university, and a certified translation.

[illegible] the same way on all documents you must submit documentation to explain how and why your name differs and submit one [illegible] to support the name change; Passport, INS card, birth certificate, court document, marriage license, court decree.

11. How have you satisfied Maryland's *written* *and* *oral* English language competency requirements?
(See *English Language Competency Requirements for Medical Licensure in Maryland* in the introductory material included with your application.)

a. ☒ I graduated from a medical school or, after at least three years of attendance, a high school (includes GED), undergraduate college, or university where English was the *only* language of instruction throughout (you must provide documentation); or

b. I passed either ☐ the TOEFL or ☐ the ECFMG English test after December 31, 1973 AND I passed the ☐TSE or ☐OPI.
If you have taken the Test of English as a Foreign Language (TOEFL) and either the Test of Spoken English (TSE) or the Oral Proficiency Interview (OPI), please request that Education Testing Service and/or Language Testing International send verification of your scores directly to the Board.

Are you claiming speech impairment? ☒ NO ☐ YES If "YES," please write or call the Board for additional information.

Stop! Following this page you will find Form MBP IML2, *Verification of Education and English Language Instruction*. Complete Part 1 of form IML2, send it to the institution which granted your medical degree, or to the institution where you satisfied Maryland's English language competency requirements, if it was other than your medical school. Please instruct the institution to mail the completed IML2 directly to the Board in an envelope that clearly bears the institution's name and address. Forms not received directly from the institution will not be accepted.

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Initial Medical Licensure
POSTGRADUATE TRAINING
INFORMATION

Print Your David A. Chang

12. **POSTGRADUATE TRAINING** (DO NOT ATTACH RESUME OR CURRICULUM VITAE) List in chronological order ALL postgraduate training undertaken in the United States, its territories or possessions, Puerto Rico, or Canada regardless of whether you did or did not complete the program, and regardless of whether you were or were not compensated. (Copies of training certificates are helpful, but not required.)

NOTE: On a case by case basis, the Board may consider **full time teaching in an LCME accredited medical school in the United States** as an alternative to the accredited postgraduate clinical medical education required in the Code of Maryland Regulations 10.32.01.03D. Applicants who intend to request consideration of teaching experience as an alternative to accredited postgraduate clinical medical education should contact the Board's licensure division for further information.

Effective October 1, 2000, graduates of all medical schools NOT in the U.S., its territories or possessions, Puerto Rico, or Canada are required to submit evidence acceptable to the Board of successful completion of 2 years of training in a postgraduate clinical medical education program accredited by an accrediting organization recognized by the Board (ACGME, AOA, or equivalent). If you have not met this requirement, DO NOT submit this application.

A Fifth Pathway Program graduate must have been a U.S. citizen during the time of medical education and must have successfully completed two years of ACGME accredited postgraduate clinical medical education after successfully completing a Board approved Fifth Pathway program. If you have not met these two criteria, DO NOT SUBMIT THIS APPLICATION.

If after 10/1/92 you passed any medical licensing exam (or part, step, or component thereof) that you failed three times, either before or after 10/1/92, then you must successfully complete another year of ACGME/AOA accredited clinical postgraduate training in addition to the year(s) usually required by Maryland. All of the additional year must have begun after the date of the last fail. Teaching will not be accepted as an alternative to a year required following three or more fails. If you have not met this requirement, DO NOT submit this application. If you failed any part, step, or component of a medical exam four times, DO NOT SUBMIT THIS APPLICATION; you are not eligible for medical licensure in Maryland.

NOTE: Postgraduate training program cycles usually run from July 1 to June 30. If the dates of your postgraduate training are not within the usual cycle, fall short of the complete cycle, or extend beyond the usual cycle, please attach a complete explanation of why your training was "off-cycle."

PG Year #	Place of Training / Address	Specialty	From (month/year)	To (month/year)	Accredited by
1	Johns Hopkins University; 600 N. WOLFE ST BALTIMORE, MD 21287	OBGYN	07 04	06 05	ACGME ☒ AOA ☐ RCPSC ☐
2	as above	OBGYN	07 05	06 06	ACGME ☒ AOA ☐ RCPSC ☐
3	as above	OBGYN	07 06	06 07	ACGME ☒ AOA ☐ RCPSC ☐
4	as above	OBGYN	07 07	06 08	ACGME ☒ AOA ☐ RCPSC ☐
					ACGME ☐ AOA ☐ RCPSC ☐

(ATTACH A SEPARATE SIGNED AND DATED PAGE IF ADDITIONAL SPACE IS NEEDED)

STOP! Following page 6 you will find Form MBP IML3, *Verification of Postgraduate Medical Education.* For each of the programs you have listed above, complete Part I of the IML3 and send a *copy (front and back) of the IML3 to the Program Director. Contact all programs before you send the IML3 as many programs now charge a fee for verification of training, Which is the responsibility of the applicant.

*** Remember to copy both sides of Form IML3 before mailing it to the Program Director.**

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Print Your Name: DAVID A CHANG Date: 01/23/08

13. Hospital Privileges After Postgraduate Training: Please list all hospitals where you have had privileges or have provided services **after the completion of your postgraduate training** for the five year period preceding the filing of this application. Copy this page if more space is needed and enclose each signed and dated addition between pages 6 and 7.

Hospital / Complete Address	month	year	TO	month	year
Hospital:			TO		
Complete Address:	Department				
Hospital:			TO		
Complete Address:	Department				
Hospital:			TO		
Complete Address:	Department				
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STOP! **Remember, following this page you will find MBP Form IML3, *Verification of Postgraduate Medical Education*. For each of the postgraduate medical education programs you listed above, complete Part I of the IML3 and send the IML3 to each Program Director. Please remember to copy both sides of Form IML3 if you make additional copies. Contact all programs before you send the IML 3 as some programs now charge a fee for verification of training which is the responsibility of the applicant.**

[illegible]	Print Your Name: DAVID A. CHANG	Date: 01/23/08	Page 7

14. **Medical Licensing Examinations** (USMLE, NBME, NBOME, FLEX, FLEX-Weighted Average, Medical Council of Canada, and licensing exams given by individual states prior to January 1, 1985) **DO NOT SUBMIT THIS APPLICATION until you have received written verification of having passed all parts, steps, or components of your medical licensing examinations or if you have more than 3 fails on any step, part or component of an examination.**

Identify below ALL the medical licensing examinations that you have ever taken. Ask the administering authority of each exam to send the complete medical licensing examination history and scores directly to this Board. In each examination category below, you will find information to help you contact the administering authority.

Have you ever failed any medical licensing examination (or part, step, or component thereof)? NO [X] YES [ ] Since October 1, 1992, have you passed any medical licensing examination (or part, step, or component thereof) which at any time you had failed three times? NO [X] YES [ ]

If you answered "Yes" to a. and b., you must have successfully completed another year of ACGME-accredited clinical postgraduate training, in addition to the year(s) of training usually required for licensure in Maryland. No part of the additional year may have been taken before the date of the last fail. If you have not met this requirement, you are not eligible for licensure in Maryland at this time. DO NOT submit this application until you have fulfilled this requirement. **DO NOT SUBMIT AN APPLICATION IF YOU HAVE FAILED ANY PART, STEP, COMPONENT OR APPROVED EXAMINATION COMBINATION MORE THAN 3 TIMES You are not eligible for medical licensure in Maryland. For a complete explanation see enclosed notice regarding the regulation change effective July 22, 2002.**

a. **State Board Examination** List state(s): N/A
STATE BOARD DOES NOT INCLUDE STEP 3 OF USMLE, ORAL EXAMS, OR INTERVIEWS. State Board Examinations were licensing exams given by individual states. **State Board Examinations taken after December 31, 1984 are not accepted for licensure in Maryland.**

Following page 8, you will find supplemental form MBP IML7, *State Board Licensure and Examination Certification*. Send a copy of this form to the state(s) which administered your licensing exam and ask the state(s) to send your exam results directly to the Maryland Board of Physicians. Also send a copy to each state that has ever issued you a license. **NOTE: Many states charge a fee for exam transcripts. Contact each state board**

Federation of State Medical Boards (See reverse if you took a combination of these exams or combined either with the NBME exams)

b. [ ] FLEX-Weighted Average: **All FLEX-Weighted exams prior to 1985 must have been taken in one sitting (3 consecutive days). Flex weighted average exams taken in more than one sitting must have current ABMS or AOA Board Certification unless you are currently certified by a member board of the American Board of Medical Specialties.**

c. [ ] FLEX Components 1 and 2: **Examinations must be passed within 5 years of each other.**

d. [X] USMLE Steps 1, 2, and 3: **Passing scores on all parts must have been completed within a 10-year period beginning with the month and year when the applicant first passed either step 1 or step 2.**

If you took any of the above examinations you must ask the Federation of State Medical Boards (FSMB) to send your transcripts to the Board by accessing their website at www.fsmb.org. *Click transcript requests.*

e. [ ] **National Board of Medical Examiners** (See reverse if you combined this examination with FLEX or USMLE exams)

If you have received NBME certification, ask NBME to send to the Board both the Endorsement of Certification and the Record of Scores. All requests must be made through the NBME website at http://www.nbme.org/programs/nbmecert.htm
If you took NBME exams but were not certified, or you took NBME as part of hybrid exams, ask NBME to send only your Record of Scores.

f. [ ] **National Board of Osteopathic Medical Examiners Certifications issued before January 1, 1971 are not accepted for licensure in Maryland.**

If you have received NBOME certification, ask NBOME to send to this Board the verification of certification and the complete history of your medical examinations. Contact NBOME at 773-714-0622 for instructions and fee information.

g. [ ] **Medical Council of Canada**
Licentiate of the Medical Council of Canada
Please request that verification of your Licenciate Certification and a complete LMCC examination history be sent directly to this Board. Call MCC at 613-521-6012 for instructions and fee information.

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CONTINUED ON PAGE 8

[illegible] Licensure
[illegible] EXAMS
[illegible]

Print Your Name: DAVID A CHANG Date: 01/23/08

HYBRID EXAMINATIONS

The following combinations are the only hybrid examinations accepted by the Maryland Board.

Passing scores on all parts of hybrid examinations must have been completed within a 10-year period, beginning with the month and year the examinee first passes a part or component or step of the combined examination. ALL HYBRID EXAMINATIONS MUST HAVE BEEN COMPLETED BEFORE JANUARY 1, 2000.

- h. ☐ USMLE 1 + NBME II + NBME III
- i. ☐ USMLE 1 + USMLE 2 + NBME III
- j. ☐ USMLE 1 + NBME II + USMLE 3
- k. ☐ NBME I + USMLE 2 + USMLE 3
- l. ☐ NBME I + USMLE 2 + NBME III
- m. ☐ NBME I + NBME II + USMLE 3
- n. ☐ FLEX 1 + USMLE 3
- o. ☐ FLEX 2 + USMLE 1 + NBME II
- p. ☐ FLEX 2 + USMLE 1 + USMLE 2
- q. ☐ FLEX 2 + NBME I + USMLE 2
- r. ☐ FLEX 2 + NBME I + NBME II

- If your hybrid exams included any part of the NBME examination, contact NBME at http://www.nbme.org/programs/nbmecert.htm. or call 215-590-9592 for instructions and request that your Endorsement of Certification *and* your Record of Scores be sent directly to the Board of Physician Quality Assurance.
- If your hybrid exams included only FLEX and USMLE examinations, request your transcript from the Federation of State Medical Boards at www.fsmb.org.

15. Licensing History:

a. ☒ I have never been licensed in the U.S., its territories, or Puerto Rico and have never been licensed or registered in Canada.

b. ☐ I have an application for license pending in the following states: ________, ________, ________, ________, ________

c. Please list below all licenses ever issued to you by a U. S. state/territory or Puerto Rico. Also list all Canadian licenses and registrations.

d. Has any disciplinary action ever been taken against your license? ☐ No ☐ Yes If yes, please enclose an explanation.

STATE (Or Puerto Rico or Canadian Province)	LICENSE NUMBER or Registration Number	CURRENT STATUS					
		Active	Inactive	Expired/Lapsed	Surrendered in good standing	Surrendered / Suspended	Revoked

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(If more space is needed, please attach an additional signed and dated sheet.)

Stop! Following this page you will find form MBP IML7. Complete Part 1 of form IML7 and send a copy to each medical board in the U.S., its possessions and territories, Puerto Rico, and Canada that ever issued you a license/registration or administered to you a state/provincial licensing examination. Please check with each board first to determine if a fee is charged for the verification. The addresses and telephone numbers of all U.S. state medical boards can be found on the Federation of State Medical Board internet site at www.fsmb.org.

Print Your Name: DAVID A. CHANG Date: 01/23/08

16. **Check YES or NO.**

YES	NO	
[X]	[ ]	Did you successfully complete a medical licensing exam (USMLE, NBME, etc.) within the 15-year period prior to filing this application?
(N/A) [X]	[ ]	During the past 10 years, have you maintained uninterrupted licensura since you were first issued a license in the United States, its territories, Puerto Rico, or Canada? (Unlicensed practitioner under Johns Hopkins – resident –)
[ ]	[X]	Do you have lifetime certification from, or within the past 10 years have you been certified or recertified by, a specialty board recognized by the American Board of Medical Specialties, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada?

If "YES," in which specialty were you certified? ______ Date certified ______

⇒ **If you have answered "NO" to all three of the above questions, you MUST take the Special Purpose Examination. After you submit this application, contact the Federation of State Medical Boards at 817-571-2949 and arrange to take the SPEX in Maryland, and have scores sent to the Maryland Board directly.**

17. **Character and Fitness Questions** (Check either YES or NO)

	YES	NO	
a	[redacted]	[redacted]	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, denied your application for licensure, reinstatement, or renewal?
b	[redacted]	[redacted]	Has a state licensing or disciplinary board (including Maryland), or a comparable body in the armed services, taken action against your license? Such actions include, but are not limited to, limitations of practice, required education admonishment, reprimand, suspension, or revocation. [Refer to the document *Grounds for Board Action in Maryland* included in your application packet.]
c	[redacted]	[redacted]	Has any licensing or disciplinary board in any jurisdiction (including Maryland), or a comparable body in the armed services, filed any complaints or charges against you or investigated you for any reason?
d	[redacted]	[redacted]	Have you ever withdrawn your application for a medical license or other health professional license?
e	[redacted]	[redacted]	Has a hospital, related health care institution, HMO, or alternative health care system investigated you or brought charges against you?
f	[redacted]	[redacted]	Has a hospital, related health care facility, HMO, or alternative health care system denied your application for, or failed to renew your privileges; or limited, restricted, suspended, or revoked your privileges in any way?
g	[redacted]	[redacted]	Have you committed a criminal act to which you plead guilty or nolo contendere, or for which you were convicted or received probation before judgement?
h	[redacted]	[redacted]	Have you committed an offense involving alcohol or controlled dangerous substances to which you plead guilty or nolo contendere, or for which you were convicted or received probation before judgement? Such offenses include, but are not limited to, driving while under the influence of alcohol and/or controlled dangerous substances.
i	[redacted]	[redacted]	Excluding minor traffic violations, are you currently under arrest or released on bond, or are there any current or pending charges against you in any court of law?
j	[redacted]	[redacted]	Do you illegally use drugs?
k	[redacted]	[redacted]	Do you have any physical or mental condition that currently impairs your ability to practice medicine or that would cause reasonable questions to be raised about your physical, mental, or professional competency?
l	[redacted]	[redacted]	Have you ever been named as a defendant in a medical malpractice action?
m	[redacted]	[redacted]	Are you in default of a service obligation that you incurred by receiving State or federal funds for your medical education?
n	[redacted]	[redacted]	Have you failed to make arrangements to satisfy State or Federal loans that financed your medical education?
o	[redacted]	[redacted]	Has your employment by any hospital, HMO, other health care facility or institution, or military entity been terminated for disciplinary reasons?
p	[redacted]	[redacted]	Have you voluntarily resigned from any hospital, HMO, other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?
q	[redacted]	[redacted]	Has the use of drugs and/or alcohol ever resulted in an impairment of your ability to practice your profession?
r	[redacted]	[redacted]	Have you surrendered your license or allowed it to lapse while you were under investigation by any licensing or disciplinary board of any jurisdiction or any entity of the armed services?

MARYLAND BOARD OF PHYSICIANS RECEIVED 2008 FEB 15 AM 11:25

⇒ **If you answered "YES" to any of the questions in item 17, on the following page please list all adverse actions taken against you and provide a complete explanation. Attach any supporting documentation that applies (copies of all complaints, malpractice claims, adverse or disciplinary actions, arrests, pleadings, judgements, or final orders). Sign and date all pages submitted.**

Print Your Name: DAVID A CHANG Date: 01/23/05

18 a. If you answered "YES" to any of the questions in item 17, please provide an explanation below and attach all complaints, pleadings and judgments. Attach additional signed and dated pages as needed.

18 b. If you answered yes to 17L - answer the following questions:

1. Total number of malpractice claims ever filed in which you were named as a defendant? ______________

2. Total number of malpractice claims ever paid (settlement / judgment) in which you were named as a defendant? ______________

3. Within the last 60 months (5 years) provide the following:
Total number of medical malpractice claims filed __________ ; paid (settlement / judgment) __________; or dismissed ________; in which you were named as a defendant.

4. For a claim filed at any time, but paid (settlement / judgment) within the last 60 months (5 years), list each claim by claimants name; describe the disposition of each claim; and provide a copy of the complaint, pleading, and judgment of each medical malpractice claim.

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I have attached the following number of pages to this application: ____________________

STATE OF MARYLAND
MARYLAND BOARD OF PHYSICIANS
4201 Patterson Avenue ■ P.O. Box 2571
Baltimore, Maryland 21215-0095
Telephone: 410-764-4777 or toll free 1-800-492-6836

Follows page 4 of the application

VERIFICATION OF EDUCATION AND ENGLISH LANGUAGE INSTRUCTION

Part 1 APPLICANT: Complete Part 1 and send to the institution which issued your medical degree. If you satisfied Maryland's English language competency requirements somewhere other than your medical school, also send a copy of this form to that institution and ask them to return the completed form directly to the Board.

Name: CHANG (Print last name and generational indicator (Jr., Sr., II, III, etc.)) DAVID (First name) AUGUSTO (Middle name)

Date of Birth: Month Day Year [redacted] **Social Security Number:** [redacted]

School Attended NEWTON COLLEGE (High school)
Only medical school, undergraduate school, or high school

Affiliated with (if applicable): N/A
Name of institution that conferred your degree, if different from medical college attended

Attended from: 1982 to 12/1993 **Date of Graduation:** 12/1993

Part 2 REGISTRAR, DEAN, PRINCIPAL or OTHER AUTHORIZED OFFICIAL: Please complete this form and mail it to the above address.

I hereby certify that the above-named individual attended this institution during the inclusive dates from

Month Day Year 03 12 82 to Month Day Year 12 18 93 ; that all academic studies were taught in the language(s) of ENGLISH ; ~~that all clinical clerkships were taught in the language(s) of~~ N/A ; and that he/she was conferred the degree of

☐ M.D. ☐ D.O. ☐ M.D./Ph.D ☐ M.B.B.S. ☐ M.B.B.Ch ☒ Other: Graduation diploma (specify)

on Month Day Year 12 18 93 after he/she had satisfied all prerequisite obligations.

DAVID MITCHELL
Printed Name of Authorized Official

NEWTON COLLEGE
Name of Institution

HEAD OF UPPER SCHOOL
Title of Authorized Official

511 4790460
Telephone Number

511 4790430
Fax Number

D Mitchell
Signature of Authorized Official

21/02/2008
Date

SEAL OF THE INSTITUTION

COLEGIO NEWTON * Jefe de Nivel * UPPER SCHOOL

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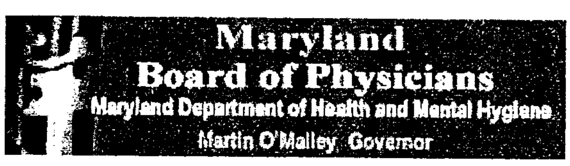


GENERAL APPLICATION
INFORMATION
ONLINE LICENSE RENEWAL

DO NOT MAIL THIS COPY TO THE BOARD. IF YOU WOULD LIKE TO SUBMIT A PAPER APPLICATION AND NOT COMPLETE YOUR RENEWAL ONLINE, PLEASE LOG OUT, RETURN TO WWW.MBP.STATE.MD.US, AND CLICK ON "DOWNLOAD FORMS" TO DOWNLOAD THE PAPER APPLICATION.

Application for renewal of: **Physicians**

Renewal Fee: $618.00

License No. D0067401

Dr. David Augusto Chang

EMAIL ADDRESS: This is your email address on file. If it has changed, please edit below. If you have no email address please indicate by checking the checkbox below.

Email Address [redacted]

I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2008. If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

3a. Non-Public Address: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street	[redacted]
Street (2)	[redacted]
Street (3)	
City	[redacted]
State	[redacted] — If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	[redacted]
Country	United States

3b. Public Address: This address, usually your office, is available to the public and will be posted on the Internet. **If you do not designate a public address, your non-public address will be posted on the Internet.**

Check if Public Address is the same as your Non Public address (the address above will be automatically entered below.)

Street	Suite 201
Street (2)	17 Fontana Lane
Street (3)	
City	Baltimore
State	Maryland — If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	21237
Country	United States

PERSONAL AND PROFESSIONAL - PART 1

4. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction — (•) Yes ( ) No

5a. Are you engaged in the direct care of patients in the State of Maryland? Answer yes if you saw one or more patients within the period since July 1, 2006 or initial licensure or reinstatement in Maryland whichever is more recent. — (•) Yes ( ) No

5b. If you answered **NO** to the previous question, did your practice include making decisions that had direct impact on patient care in Maryland (such as radiology, pathology, or medical director)? — ( ) Yes ( ) No

CHARACTER AND FITNESS

6. The following questions pertain to the period since July 1, 2006. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***

* All questions must be answered Yes or No.

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed service denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?.

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

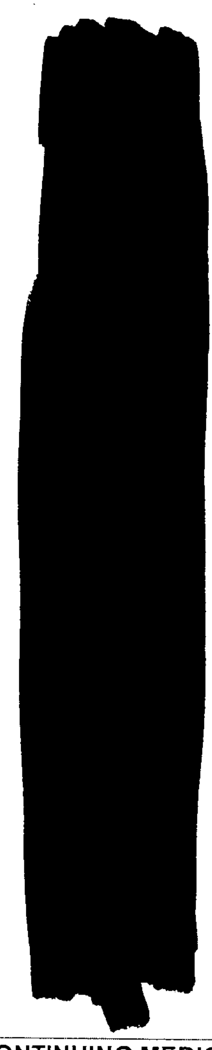
f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j.



Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION

○ **a. CME met**. I have earned 50 credit hours of Category 1 continuing medical education during the two years prior to this renewal.

● **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2006 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

○ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL - PART 2

8. Ethnicity and Race: (Select all that apply)

✓ Hispanic or Latino
American Indian or Alaska native
✓ Asian
Black or African American
Native Hawaiian or other Pacific Islander
✓ White
Other

9. Are you employed by the Federal Government?

○ Yes ● No

10. Do you plan on ending your medical practice in the next 2 years?

Yes ● No Not Applicable

11. Which best describes your current area(s) of concentration:

Primary Concentration Gynecology
Secondary Concentration None

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification None
Secondary Certification None

HEALTH CARE ALTERNATIVE DISPUTE RESOLUTION QUESTIONS

13. The following questions pertain to the period since July 1, 2006. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***

* All questions must be answered Yes or No.

Yes ● No a. Have you been the subject of professional discipline?

Yes ● No b. Have you, your partners or associates or anyone in your immediate family or household, been sued or had a claim filed against you or any of them for medical malpractice?

Yes ● No c. Have you testified as a medical witness in a judicial or administrative proceeding?

Yes ● No d. Have you been an arbitrator?

Yes ● No e. Are you currently an arbitrator?

Yes ● No f. Are you, or any member of your immediate family or household, currently a party in a medical malpractice case?

Yes ● No g. Is there any reason why you could not hear and decide impartially a health care malpractice claim solely on the basis of the law and the evidence presented?

PRACTICE

14. Do you currently practice medicine? ● Yes No

If you answer YES to Question 14, you will be required to answer Questions 16-31. If you answer NO you will be required to answer Question 15.

16. What percent of your average work day is spent in personally providing PRIMARY/PREVENTIVE CARE SERVICES in Maryland? 0 %

Use whole numbers

17. If ALL OFFICES are located outside Maryland, do you treat Maryland residents? Yes No ● Not Applicable

18. What is the total number of practice/office locations at which you personally work within Maryland? If none, enter 0. 1

19. Primary Practice / Office Location Please answer all Primary Practice questions

Organization Name	Gynemed
Street Address	17 Fontana Lane
Street2	Suite 201
City	Baltimore
State	Maryland
Zip Code	21202
Jurisdiction	BALTIMORE CITY
Employer Tax ID	[redacted]

At this site, what is the average number of hours per week you are available for ALL PATIENT CARE? If none, enter 0. 32 Hours

Setting	Freestanding Ambulatory Surg Ctr
Practice	Other Contractual -Associate Staff (Individual only)
Primary Role	Clinical/Direct Patient Care
Secondary Role	None
Private/Public	Private-For profit

20. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients. In your practice, are computers or other forms of information technology used: Please answer all information technology questions

- (•) Yes ( ) No — A. To obtain information about treatment alternatives or recommended guidelines?
- ( ) Yes (•) No — B. To send prescriptions electronically to a pharmacy?

  If you answered **yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. ____ %
- ( ) Yes (•) No — C. To generate reminders for you about preventive services needed for your patients?
- ( ) Yes (•) No — D. To access patient notes, medication lists, or problem lists?
- ( ) Yes (•) No — E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?
- (•) Yes ( ) No — F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?
- (•) Yes ( ) No — G. To communicate about clinical issues with patients by email?
- (•) Yes ( ) No — H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?
- (•) Yes ( ) No ( ) Not Applicable — I. If you admit patients to the hospital, does the hospital where most of your patients are treated have computerized systems to order tests and medications?

21. Check if you have a Secondary Practice / Office Location

If you have a secondary practice / office location, after checking the box above, you will see a series of questions that must be completed.

22. Do you participate in the Maryland Medical Assistance Program (Medicaid)? — Yes / No / Not Applicable

23. If YES, are you accepting new Maryland Medical Assistance patients? — Yes / No

24. Do you participate in Medicare? — Yes / No / Not Applicable

25. If YES, are you accepting new Medicare patients? — Yes / No

26. **National Provider Identifier** (NPI): If you have your NPI number, please enter. Otherwise, enter the word "None".

27. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income) — Yes / No / Not Applicable

28. Do you offer uncompensated (charity) care? — Yes / No / Not Applicable

29. If YES, report the number of hours you personally provide in uncompensated care in a month. Use whole numbers. — Hours

30. Is a Physician Assistant, Nurse Practitioner, or Nurse Midwife included as part of your practice (employee or on staff)? — Yes / No

31. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- Not Applicable (Do not complete below)
- I do not practice in Maryland.
- I do not employ anyone in my practice in Maryland.
- I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.
  - If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date — Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

32. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone uld be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

Chemical   Biological   Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.us/volunteer.htm.

Thank you for your assistance!

AFFIRM AND SELECT PAYMENT

Affirmation and Authorization

(Please check each box to affirm the following questions)

✓ I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

✓ I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

✓ I shall inform the Board, by certified mail, return receipt requested, within 30 days of:

(a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period;

(b) change in any answer that was originally given in this application.

✓ **Check Here** if you wish to have the option of viewing your completed application online ***after*** you renew your license. Otherwise, your application will not be available online for later viewing. If selected, viewing is available until 12/1/08.

Select a Payment Option: ***License Fee $***

- If you select the credit card option, you will be taken to a secure Bank of America credit card processing site to pay your application fee. You will then return to the license site to receive your receipt.
- If you select the Send Check option, you will receive an invoice. However, your application will not be complete until the payment is received by the Board.

Send your check and invoice (which you will receive next) to: **MBP Renewal Unit P.O. Box 17314 Baltimore, MD 21297-0475**

Your license will not be renewed until payment is received. Please allow up to 7 business days for receipt of your payment.

○ **Third Party Payer** [ ] Enter Payer's name

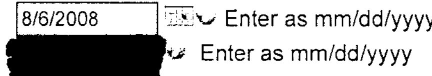
Please note: This is NOT for credit cards. This is only to generate an invoice to give to another organization that is paying your renewal fee, called the Third Party Payer. Example: Your employer or hospital you work for is paying your renewal fee for you.

Remember to notify your payer that you have completed the application. Give a copy of your electronic invoice (which you will receive next) to your third party payer. Your license will not be renewed until payment is received. Please allow up to 7 business days for receipt of your payment.

Please provide your electronic signature below:

Name [David Augusto Chang] Enter your name

Today's Date 8/6/2008 Enter as mm/dd/yyyy



Date of Birth Enter as mm/dd/yyyy

PAYMENT RECEIPT

Date Application was Submitted
License Renewal Confirmation No.
Payment Method
Amount Due
Third Party Payer
Receipt Sent to Email:

---------- END OF APPLICATION ----------

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0067401** Dr. David Augusto Chang

2.	Individual National Provider Identifier NPI: [redacted] ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. **EMAIL ADDRESS**: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

[redacted]

☐ I do not have an email address

Address Changes (Non-Public and Public):

You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2010 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address**: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street	[redacted]
Street (2)	[redacted]
Street (3)	
City	[redacted]
State	[redacted]
	If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	[redacted]
Country	United States

4b. **Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street	Suite 201
Street (2)	17 Fontana Lane
Street (3)	
City	Baltimore
State	Maryland
	If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	21237
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2008. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***

* All questions must be answered Yes or No.

a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

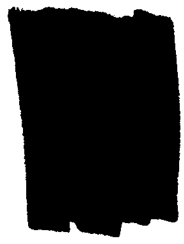
k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?



p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

○ **a. CME met.** I have earned 50 credit hours of Category 1 continuing medical education during the two (2) years prior to this renewal.

○ **b. First Renewal & NPO.** I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2008 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

◉ **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8. Ethnicity and Race: (Select all that apply)

spanic or Latino

erican Indian or Alaska native

ian

ack or African American

tive Hawaiian or other Pacific Islander

hite

her

---

9. Are you employed by the Federal Government?

○ Yes ◉ No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer *Yes* to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

○ Yes ◉ No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

---

11. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology

Secondary Concentration: Obstetrics & Gynecology, Reproductive

---

12. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: None

Secondary Certification: None

---

13. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	45	hours per week
b. Research	1	hours per week
c. Teaching	0	hours per week
d. Administration & Other	8	hours per week
Total Hours	**54**	hours per week

---

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

---

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) 1

b. Number of locations outside of Maryland (if none, enter 0) 0
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
○ Yes ○ No ○ Don't know

---

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) 1

b. Number of hospitals outside of Maryland (if none, enter 0) 0

18. **Primary Practice / Office Location Primary Practice / Office Location**

Please answer all Primary Practice questions

a. Organization Name: Gynemed

b. Street Address: 17 Fontana Lane

c. Street2: Suite 201

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Baltimore

e. State: Maryland

f. Zip Code: 21237

g. Jurisdiction: BALTIMORE CITY

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h. Employer Tax ID: none

What is Employer tax ID?

Enter "None" if you do not have an Employer tax ID

---

i. Please select one of the following related to the NPI used for billing insurers:

- ○ **I use an Organizational NPI for billing. Please Enter >**
- ◉ **I use my Individual NPI for billing.**
- ○ **I do not bill public or private insurers.**

Organizational NPI

---

j. You indicated in Question 13a, **45** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location?

If none, enter 0.

40 Hours

---

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Other Contractual-Associate Staff (Individual only)

---

19. Secondary Practice / Office Location

No Secondary Location indicated from your response in Question 16.

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

---

20. Information Technology (Primary Practice / Office Location)

Please answer all Primary Practice Information Technology questions

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in question 18.

◉ Yes ○ No — A. To obtain information about treatment alternatives or recommended guidelines?

○ Yes ◉ No — B. To send prescriptions electronically to a pharmacy?

If you answered **Yes** to 20B, what percentage of prescriptions are submitted electronically? Use whole numbers. %

C. To generate reminders for you about preventive services needed for your patients?

○ Yes ◉ No

○ Yes ◉ No D. To access patient notes, medication lists, or problem lists?

◉ Yes ○ No E. For clinical data and image exchanges **WITH OTHER PHYSICIANS**?

◉ Yes ○ No F. For clinical data and image exchanges **WITH HOSPITALS AND LABORATORIES**?

○ Yes ◉ No G. To communicate about clinical issues with patients by email?

◉ Yes ○ No H. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?

---

21. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?

○ Yes, all electronic ○ Yes, part paper and part electronic ◉ No ○ Don't know

21a. If **No**, please indicate your most significant reason for not using electronic medical records.

○ Capital cost outlays ○ Risk of privacy breaches ○ Retiring soon
○ Overburdened staff ○ Lack of technology standards ◉ Not my decision
○ Physician resistance to adoption ○ Intangible benefits

---

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ◉ Yes ○ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ◉ Yes ○ No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ◉ Yes ○ No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ○ Yes ◉ No

c1. If **Yes**, are you accepting new Medicare patients? Yes No

---

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

○ Yes ○ No ◉ NA

---

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

○ Yes ○ No

---

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

- (●) Not Applicable (Do not complete below)
- ( ) I do not practice in Maryland.
- ( ) I do not employ anyone in my practice in Maryland.
- ( ) I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date — Enter as MM/DD/YYYY Enter as MM/DD/YYYY

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime * [redacted]

Nighttime* [redacted]

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

Chemical Biological Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at http://bioterrorism.dhmh.state.md.us/volunteer.htm.

Thank you for your assistance!

APPLICATION PACKET FOR EXEMPTION FROM LICENSE FEE

---

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

Please check the first 3 boxes to certify and affirm your renewal application.

- [x] a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.
- [x] b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, governmen agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.
- [x]

c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2010.

29. Please provide your electronic signature (type your name) below:

Name	David Augusto Chang
Today's Date	7/20/2010
Last four digits of Social Security Number:	

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

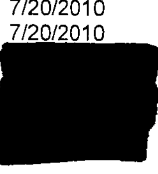
Your renewal fee is:

◉ **Credit Card** ○ **Send Check** ○ **3rd Party Check** **3rd Party Payer:**

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	7/20/2010
Date Application Submitted	7/20/2010
Confirmation Number	
Payment Method	
Amount Paid	
Credit Card Approval No.	



Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0067401** Dr. David Augusto Chang

2.	Individual National Provider Identifier NPI: [redacted] ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. **EMAIL ADDRESS**: This is your email address on file. If it has changed, please edit below. If you do not have an email address please indicate by checking the checkbox below.

[redacted]

☐ I do not have an email address

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2012 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address**: This address is for Board use only and is **where your license will be mailed**. However, if no public address is listed, this address will also be made available to the public.

Street	[redacted]
Street (2)	
Street (3)	
City	[redacted]
State	[redacted]
	If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	[redacted]
Country	United States

4b. **Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

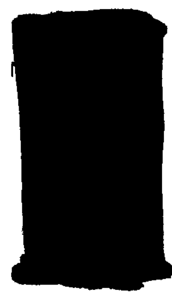
☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street	Suite 201
Street (2)	17 Fontana Lane
Street (3)	
City	Baltimore
State	Maryland
	If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode	21237
Country	United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2010. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.



a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board)

or an entity of the armed services?

c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

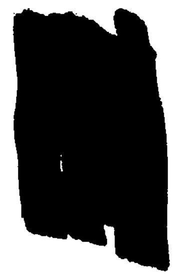
m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

Patient claims that she was injected wiht an "undated" medication and therefore this resulted in blood clots to her arm that required surgery to remove the clots/vein. Case is pending.

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p.



Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

(●) **a. CME met**. I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two year period immediately preceding submission of this application for license renewal. *Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.*

( ) **b. First Renewal & NPO**. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2010 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

( ) **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender (●) Male ( ) Female

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) (●) Yes ( ) No

S[redacted]ct one or more of the following racial categories:

[redacted]rican Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, [redacted]ho maintains tribal affiliations or community attachment.)

[redacted]n (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, [redacted]nbodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

[redacted]k or African American (A person having origins in any of the black racial groups of Africa.)

[redacted]e Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

[redacted]e (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

---

9. Are you employed by the Federal Government?

( ) Yes (●) No

---

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer *Yes* to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

( ) Yes (●) No

b. In an accredited fellowship (subspecialty) training program?

○ Yes ◉ No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology
Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: None
Secondary Certification: None

---

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☐ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☐ Virginia
☐ Arkansas	☐ Hawaii	☐ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☐ Illinois	☐ Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ District of Columbia	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 48

13b. Please indicate below how the hours in your typical work week are allocated. The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	35	hours per week
b. Research	0	hours per week
c. Teaching	2	hours per week
d. Administration & Other	4	hours per week
Total Hours	**41**	hours per week

---

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next 2 years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

---

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) [2]

b. Number of locations outside of Maryland (if none, enter 0) [0]

If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?

○ Yes ○ No ○ Don't know

---

17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) [1]

b. Number of hospitals outside of Maryland (if none, enter 0) [0]

---

18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: Gynemed

b. Street Address: 17 Fontana Lane

c. Street2: Suite 201

Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: Baltimore

e. State: Maryland

f. Zip Code: 21237

g. Jurisdiction: BALTIMORE COUNTY

---

h. Employer Tax ID: [redacted] - [redacted]

If you do not have an EIN enter 00-0000000

What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter >

Organizational NPI

◉ I use my Individual NPI for billing.

○ I do not bill public or private insurers.

---

j. You indicated in Question 13a, **35** hours of Patient Care Related Activities during a typical work week.

How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? [29] Hours

If none, enter 0.

---

k. Setting: Freestanding Ambulatory Surg Ctr

l. Private/Public: Private-For profit

m. Practice: Single-Specialty Group

Please answer the following regarding staffing at this practice/office location on a typical day. Definition of mid-level medical providers is listed below.

If none, enter 0; if you don't know the number, enter 999

Number of physicians (MDs, DOs, residents, fellows) including yourself at this location. [1]

Number of mid-level medical providers at this location. [1]

Mid-level medical providers: nurse practitioners, nurse midwives, nurse anesthetists and physician assistants.

---

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Whole Womans Health

b. Street Address: 7648 Belair Rs

c. Street2:

Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Baltimore

e. State: Maryland

f. Zip Code: 21236

g. Jurisdiction: BALTIMORE COUNTY

---

h. Employer Tax ID: [redacted] [redacted] If you do not have an EIN enter 00-0000000

What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter >

◉ I use my Individual NPI for billing. Organizational NPI

○ I do not bill public or private insurers.

---

j. You indicated in Question 13a, **35** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? [7] Hours
If none, enter 0.

---

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Other Contractual -Associate Staff (Individual only)

20-21 Health Information Technology questions has been moved to a seperate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

a. Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc. ◉ Yes ○ No

b. Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization) ◉ Yes ○ No

b1. If **Yes**, are you accepting new Maryland Medical Assistance patients? ◉ Yes ○ No

c. Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)? ○ Yes ◉ No

c1. If **Yes**, are you accepting new Medicare patients? ○ Yes ○ No

---

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)

○ Yes ○ No ◉ NA

---

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).

[0] hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), answer Q.25. Otherwise skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel (sometime called direct, concierge, or retainer-based practice)?

○ Yes ○ No

---

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

◉ Not Applicable (Do not complete below)

○ I do not practice in Maryland.

○ I do not employ anyone in my practice in Maryland.

○ I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company [ ]

Policy Number [ ]

Expiration Date [ ] Enter as MM/DD/YYYY Enter as MM/DD/YYYY

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in ***Question 18 - Primary Practice / Office Location Primary Practice / Office Location***

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?

◉ Yes ○ No

b. To send prescriptions electronically to a pharmacy?

○ Yes ◉ No

If you answered Yes to 20B, what percentage of prescriptions are submitted electronically? [ ] % (Enter Whole number)

c. To generate reminders for you about preventive services needed for your patients?

(●) Yes ( ) No

d. To access patient notes, medication lists, or problem lists?
( ) Yes (●) No

e. For clinical data and image exchanges with other physicians?
( ) Yes (●) No

f. For clinical data and image exchanges with hospitals and Laboratories?
( ) Yes (●) No

g. To communicate about clinical issues with patients by email?
(●) Yes ( ) No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?
(●) Yes ( ) No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?
( ) Yes, all electronic ( ) Yes, part paper and part electronic (●) No ( ) Don't know

2a. If Yes, what is the name and version of the EHR system?
Select EHR System

Other

2b. If **No,** please indicate your most significant reason for not using electronic medical records.
( ) Capital cost outlays ( ) Lack of technology standards ( ) Retiring soon
( ) Overburdened staff ( ) Intangible benefits (●) Not my decision
( ) Risk of privacy breaches

3. Please answer the following Telemedicine question(s)

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 200
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?
- [ ] Second opinion
- [x] Diagnosis
- [ ] Follow-up
- [ ] Emergency
- [ ] Chronic disease management
- [x] Other (specify) Ultrasound review

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.
Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

Chemical Biological Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2012.

29. Please provide your electronic signature (type your name) below:

Name: David Augusto Chang

Today's Date: 9/5/2012

Last four digits of Social Security Number:

30. Select a Payment Option here to complete your application.

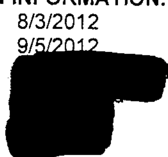
Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started 8/3/2012
Date Application Submitted 9/5/2012
Confirmation Number
Payment Method
Amount Paid
Credit Card Approval No.



Print

DO NOT MAIL THIS TO THE BOARD. RETAIN THIS APPLICATION FOR YOUR RECORDS.

Application for renewal of: **Physicians**

1. **License Number D0067401** Dr. David Augusto Chang

2.	Individual National Provider Identifier NPI: [redacted] ☐ I do not have an NPI This is the NPI entered in the field for Rendering NPI on a claim (10 digit number) NPI Information

3. **EMAIL ADDRESS**: Please enter your most current email address where we may contact you regarding your license.

Address Changes (Non-Public and Public):
You must submit a Public and Non-Public address. If either address has changed, please correct here.
Your address(es) on the online renewal application is current as of July 1, 2014 . If you requested any changes to your address(es) that are not reflected on this application, please make the change at this time. These changes will be updated in the main database.

4a. **Non-Public Address**: This address is for Board use only and is where your license will be mailed. However, if no public address is listed, this address will also be made available to the public.

Street
Street (2)
Street (3)
City
State
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode
Country United States

4b. **Public Address**: This address, usually your office, is available to the public and will be posted on the Internet. If you do not designate a public address, your non-public address will be posted on the Internet.

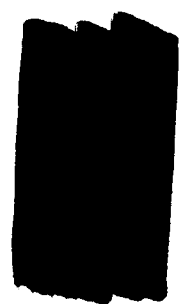
☐ Check if Public Address is the same as your Non-Public address (the address above will be automatically entered below.)

Street Suite 201
Street (2) 17 Fontana Lane
Street (3)
City Baltimore
State Maryland
If selecting a country other than USA or Canada, please choose "Foreign" as your state
ZipCode 21237
Country United States

5. Do you give the Maryland Board of Physicians permission to report your date of birth to the Federation of State Medical Boards' Physician Data Center? See instruction ◉ Yes ○ No

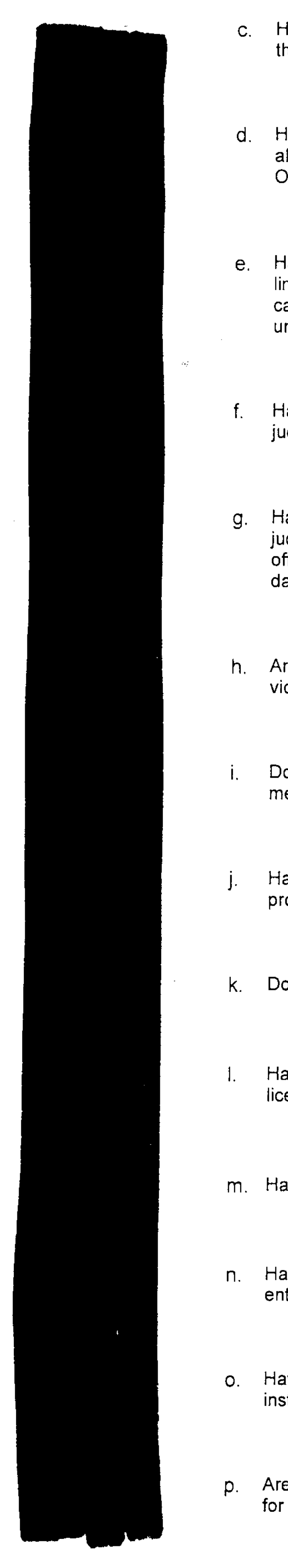
CHARACTER AND FITNESS (Question 6)

6. The following questions pertain to the period since July 1, 2012. If this is your first renewal, these questions apply to the period commencing with the date of your initial licensure or reinstatement. Check the box YES or NO next to each question. ***If you answer Yes, provide an explanation at the prompt.***
* All questions must be answered Yes or No.



a. Has any licensing or disciplinary board of any jurisdiction (except this licensing board), or any entity of the armed services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or nonjudicial punishment, for an act that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

b. Have any complaints, investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board (except this licensing board) or an entity of the armed services?



c. Has your application for a medical or health professional license been withdrawn for reasons that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system that would be grounds for action under Md. Code Ann. Health Occ. §14-404?

e. Have you had any denial of application for privileges, failure to renew your privileges, or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404?

f. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding traffic violations?

g. Have you had a plea of guilty, nolo contendere, conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

h. Are there any pending criminal charges against you in any court of law, excluding minor traffic violations?

i. Do you have a physical or mental condition that currently impairs your ability to practice medicine?

j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

k. Do you illegally use drugs?

l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction or an entity of the armed services?

m. Have you been named as a defendant in a filing or settlement of a medical malpractice action?

n. Has your employment by any hospital, HMO, related health care or other institution, or military entity been terminated for any diciplinary reasons?

o. Have you voluntarily resigned from any hospital, HMO, or other health care facility or institution, or military entity while under investigation by that institution for disciplinary reasons?

p. Are you in default of a service obligation resulting from your receipt of state or federal funding for your medical education?

q. Have you failed to make arrangements to satisfy any state or federal loans that financed your medical education?

CONTINUING MEDICAL EDUCATION (Question 7)

(◉) **a. CME met.** I have completed and have been granted credit for at least 50 credit hours of Category 1 continuing medical education activities within the two-year period immediately preceding submission of this application for license renewal. *Physician is obliged to obtain requisite documentation of CME activity and maintain documentation for a period of six years for possible inspection by the Board. For additional information on CME, see Maryland Regulations, 10.32.01.09.*

( ) **b. First Renewal & NPO**. I am exempt from CME during the renewal period because this is my first renewal after initial medical licensure in Maryland and I have completed the Board's New Physician Orientation Program. The New Physician Orientation is for **NEWLY** licensed physicians only. If you were licensed prior to September 30, 2012 or reinstated, this does not apply to you. See New Physician Orientation Program web site. **Your license will not be renewed unless you have completed the orientation.**

( ) **c. First Renewal after reinstatement.** I am exempt from CME during the renewal period because this is my first renewal after reinstatement of my medical licensure in Maryland.

PERSONAL AND PROFESSIONAL INFORMATION (Questions 8-17)

8a. Gender (◉) Male ( ) Female

8b. RACE/ETHNIC IDENTIFICATION - PLEASE CHECK ALL THAT APPLY

Are you of Hispanic or Latino origin? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) (◉) Yes ( ) No

Select one or more of the following racial categories:

merican Indian or Alaska Native (A person having origins in any of the original peoples of North or South America, including Central America, nd who maintains tribal affiliations or community attachment.)

sian (A person having origin in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, ambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

lack or African American (A person having origins in any of the black racial groups of Africa.)

ative Hawaiian or other Pacific Islander (A person having origins In the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

Vhite (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

ther

9. Are you employed by the Federal Government?

( ) Yes (◉) No

10. Please indicate if you are currently in: a) a residency program accredited by the Accreditation Council for Graduate Medical Education or an internship or residency program approved by the American Osteopathic Association; or b) a fellowship (subspecialty) training program accredited by the ACGME.

If you answer *Yes* to either a. or b. you will not be required to complete the Practice Information section (Questions 15-26) of this application.

a. In an accredited/approved internship or residency program?

( ) Yes (◉) No

b. In an accredited fellowship (subspecialty) training program?

( ) Yes (◉) No

11a. Which best describes your current area(s) of concentration:

Primary Concentration: Gynecology
Secondary Concentration: None

11b. SPECIALTY BOARD CERTIFICATION: List up to two (2) specialty areas only if certified by a recognized board of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

Primary Certification: None
Secondary Certification: None

12. Please select all states (excluding Maryland) where you hold a medical license.

☐ Alabama	☐ Florida	☐ Kentucky	☐ Nebraska	☐ Oklahoma	☐ Utah
☐ Alaska	☐ Georgia	☐ Louisiana	☐ Nevada	☐ Oregon	☐ Vermont
☐ Arizona	☐ Guam	☐ Maine	☐ New Hampshire	☐ Pennsylvania	☐ Virginia
☐ Arkansas	☐ Hawaii	☐ Massachusetts	☐ New Jersey	☐ Puerto Rico	☐ Virgin Islands
☐ California	☐ Idaho	☐ Michigan	☐ New Mexico	☐ Rhode Island	☐ Washington
☐ Colorado	☐ Illinois	☐ Minnesota	☐ New York	☐ South Carolina	☐ West Virginia
☐ Connecticut	☐ Indiana	☐ Mississippi	☐ North Carolina	☐ South Dakota	☐ Wisconsin
☐ Delaware	☐ Iowa	☐ Missouri	☐ North Dakota	☐ Tennessee	☐ Wyoming
☐ District of Columbia	☐ Kansas	☐ Montana	☐ Ohio	☐ Texas	

13a. How many weeks per year do you work? 47

13b. Please indicate below how the hours are allocated in your typical work week . The sum of these hours should reflect the number of hours in your typical work week. Definitions of these categories are listed below.

If you allocate **0 hours per week** to a. Patient Care Related Activities you will not be required to complete the Practice Information section (Questions 15-26) of this application.

Patient Care Related Activities include seeing patients, writing prescriptions, patient-related clinical activities (such as pathologic and radiologic assessments), maintaining patient records, obtaining and reviewing test results, arranging referrals, consulting with other providers about patients, talking with a patient's family members.

Research includes clinical, laboratory, and analytical research

Teaching includes the teaching of medical undergraduate & graduate students and other graduate students.

Administration & Other: Administration includes practice management (billing, contract negotiations, personnel, regulatory activities) & management of institutions or programs (health departments, health insurance, hospitals, other health-related institutions or programs); Other

Use whole numbers. No fractional hours. If none enter 0.

a. Patient Care Related Activities	30	hours per week
b. Research	0	hours per week
c. Teaching	3	hours per week
d. Administration & Other	2	hours per week
Total Hours	35	hours per week

14. If you indicated in Question 13 that you are not engaged in patient care related activities, do you intend to resume patient care related activities in the next two years?

○ Yes ○ No

PRACTICE INFORMATION (Questions 15-26)

15. Do you plan to discontinue patient care related activities in the next two years?

○ Yes ◉ No

16. Please indicate below the number of practice/office locations at which you routinely deliver patient care for reimbursement.

a. Number of locations in Maryland (if none, enter 0) | 2

b. Number of locations outside of Maryland (if none, enter 0) | 0
If you have locations outside Maryland, please answer (c) below after you answer (b).

c. Do you routinely treat Maryland patients at your practice/office location(s) outside of Maryland?
○ Yes ○ No ○ Don't know

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17. Please indicate below the number of hospitals at which you currently have admitting privileges.

a. Number of hospitals in Maryland (if none, enter 0) | 1

b. Number of hospitals outside of Maryland (if none, enter 0) | 0

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18. Primary Practice / Office Location Primary Practice / Office Location

Please answer all Primary Practice questions

a. Organization Name: GYNEMED

Organization Name2:

b. Street Address: 17 FONTANA LN

c. Street2: SUITE 201
Enter suite or room number here. (Ex. Suite 101 or Room 101)

d. City: BALTIMORE

e. State: Maryland

f. Zip Code: 21237

g. Jurisdiction: BALTIMORE COUNTY

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h. Employer Tax ID: [redacted] If you do not have an EIN enter 00-0000000
What is Employer tax ID?

---

i. Please select one of the following related to the NPI used for billing insurers:

○ I use an Organizational NPI for billing. Please Enter > ______ Organizational NPI

◉ I use my Individual NPI for billing.

○ I do not bill public or private insurers.

---

j. You indicated in Question 13a, **30** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 25 Hours
If none, enter 0.

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k. Setting: Freestanding Ambulatory Surg Ctr

l. Private/Public: Private-For profit

m. Practice: Other Contractual-Associate Staff (Individual only)

---

19. Secondary Practice / Office Location

If you have a secondary practice/office location and you've checked the box above, you will see a series of questions that must be completed.

a. Organization Name: Whole Womens Health

Organization Name2

b. Street Address: 7648 Belair Rd

c. Street2:
Enter suite or room number (Ex. Suite 101 or Room 101)

d. City: Baltimore

e. State: Maryland

f. Zip Code: 21236

g. Jurisdiction: BALTIMORE CITY

h. Employer Tax ID: [redacted] - [redacted] If you do not have an EIN enter 00-0000000

What is Employer tax ID?

i. Please select one of the following related to the NPI used for billing insurers:

- ○ I use an Organizational NPI for billing. Please Enter > Organizational NPI
- ◉ I use my Individual NPI for billing.
- ○ I do not bill public or private insurers.

j. You indicated in Question 13a, **30** hours of Patient Care Related Activities during a typical work week.
How many of those Patient Care Related Activity hours in your typical work week are delivered at this practice/office location? 5 Hours
If none, enter 0.

k. Setting: Freestanding Physician Office

l. Private/Public: Private-For profit

m. Practice: Other Contractual-Associate Staff (Individual only)

20-21 The Health Information Technology questions have been moved to a seperate section. You are required to complete the Health Information Technology section ONLY if you have a Primary Practice Location.

22. Please indicate if you participate in the following private and public insurance programs, and whether you are currently accepting new public insurance program patients.

	Question	Yes	No
a.	Participate in any PRIVATE insurance plan networks, including PPO, EPO, HMO, etc.	◉	○
b.	Participate in the MARYLAND MEDICAL ASSISTANCE PROGRAM (in either the traditional program or a Managed Care Organization)	◉	○
	b1. If **Yes**, are you accepting new Maryland Medical Assistance patients?	◉	○
c.	Participate in the MEDICARE (in either the traditional program or a Medicare Advantage Plan)?	○	◉
	c1. If **Yes**, are you accepting new Medicare patients?		○

23. Do you offer a sliding fee scale based on ability to pay? (Utilize a standardized fee reduction schedule for low-income)
○ Yes ◉ No ○ NA

24. Please report the typical number of hours per week you personally provide care to patients on a charity basis (do not include bad debt).
0 hours per week. If none, enter 0

If you are practicing as an adult primary care specialist (internal medicine, family practice, general medicine), please answer Q.25, otherwise:
☑ check this box and skip to Q.26.

25. Do you charge patients an annual fee for participating on your patient panel, sometimes called direct, concierge, or retainer-based practice?
Yes ○ No

---

26. Workers Compensation

Workers Compensation coverage: If you employ one or more persons, the Md. Code Ann. Health Occ. §1-202 requires that you verify that you are complying with the Workers' Compensation Law for your renewal to be issued.

I hereby certify:

○ Not Applicable (Do not complete below)

○ I do not practice in Maryland.

◉ I do not employ anyone in my practice in Maryland.

○ I employ one or more persons in my Maryland practice and have the following Workers Compensation coverage.

If you are a Maryland employer you must provide the information requested below.

Insurance Company

Policy Number

Expiration Date Enter as MM/DD/YYYY Enter as MM/DD/YYYY

HEALTH INFORMATION TECHNOLOGY

Please contact the Maryland Health Care Commission at 410-764-3330 for questions relating to this section.

Electronic Health Record Incentive

Beginning in 2011, physicians that adopt an electronic health record are eligible to receive an incentive either under Medicare or Medicaid. To receive this incentive, a physician must meet certain criteria, which varies depending on which program you choose. The Medicare incentive is up to $44,000 over five years and the Medicaid incentive is up to $63,750 over six years. Physicians are encouraged to learn more about these incentive opportunities by visiting the Centers for Medicare and Medicaid Services website http://www.cms.gov/EHRIncentivePrograms/

This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients at your primary office/practice location, which you listed in
Question 18 - Primary Practice / Office Location Primary Practice / Office Location

Please complete the following HIT questions for: GYNEMED

1. This question is about the use of computers and other forms of information technology, such as hand-held computers, in diagnosing or treating your patients in your office.

Are you computerized in your office:

a. To obtain information about treatment alternatives or recommended guidelines?
◉ Yes ○ No

b. To send prescriptions electronically to a pharmacy?
○ Yes ◉ No

If you answered Yes to 1b, what percentage of prescriptions are submitted electronically? %
(Enter Whole number)

c. To generate reminders for you about preventive services needed for your patients?
◉ Yes ○ No

d. To access patient notes, medication lists, or problem lists?
◉ Yes ○ No

e. For clinical data and image exchanges with other physicians?
○ Yes ◉ No

f. For clinical data and image exchanges with hospitals and laboratories?
○ Yes ◉ No

g. To communicate about clinical issues with patients by email?
◉ Yes ○ No

h. To obtain information on potential patient drug interactions with other drugs, allergies, and/or patient conditions?
◉ Yes ○ No

2. Does your primary office/practice location use electronic MEDICAL RECORDS (not including billing records)?
◉ Yes, all electronic ○ Yes, part paper and part electronic ○ No ○ Don't know

2a. If Yes, what is the name and version of the EHR system?
Other

Other: Prognosis

2b. If **No,** please indicate your most significant reason for not using electronic medical records.
○ Capital cost outlays ○ Lack of technology standards ○ Retiring soon
○ Overburdened staff ○ Intangible benefits ○ Not my decision
○ Risk of privacy breaches

3. Have you used telemedicine for any purpose in the last 12 months?
◉ Yes ○ No

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications of electronic technology by a licensed health care provider to deliver health care service(s) within the scope of practice of the health care provider at a site other than the site at which the patient is located.

3a. Approximately how many times in the last 12 months have you used telemedicine for any purpose? 200
(Enter 0 if you did not use telemedicine)

3b. If you used telemedicine, what are your common uses of telemedicine technology (mark all that apply)?
- [ ] Second opinion
- [x] Diagnosis
- [ ] Follow up
- [ ] Emergency
- [ ] Chronic disease management
- [x] Other (specify) Ultrasound review

The following questions are to be answered ONLY if your Practice Setting is one of the following:
(1) Solo; (2) Single-Specialty Group; (3) Multi-Specialty Group; or (4) HMO Group/Staff

4. Does your practice use high speed Internet?
○ Yes ○ No

4a. If Yes, select your internet provider from the list below. *Please Specify* :

5. How do you access the Internet?
○ DSL ○ Cable Modem ○ Fiber to the office ○ Wireless ○ Other ○ Unknown

6. Do you provide Wi-Fi access to your patients in your waiting area?
○ Yes ○ No ○ Unknown

PHYSICIANS EMERGENCY CONTACT INFORMATION

27. As part of Maryland's emergency preparedness efforts, the Department of Health and Mental Hygiene has identified the need for certain contact information for licensed physicians in Maryland who may be needed to respond to a catastrophic health emergency. (Public Safety Article, Sec. 14-3A-01 et seq. and Health General Article Section 18-901 et seq. sets forth the powers of the Governor and Secretary of the Department of Health and Mental Hygiene.

* Required Field

Please provide the phone number that should be used in the event of an actual emergency.

Daytime *

Nighttime*

Indicate by checking any box that applies whether you have any particular training and experience regarding the following specific agents:

Chemical Biological Radiological

If you are interested in being contacted about training opportunities provided by the Board of Physicians, please visit the Maryland Professional Volunteer Corps website at https://mdresponds.dhmh.maryland.gov/.

Thank you for your assistance!

28. CERTIFICATION AND AUTHORIZATION OF LICENSE APPLICATION

☑ a. I certify that I have personally reviewed all responses to the items in this application and that the information I have given is true and correct to the best of my knowledge and that any false information provided as part of my application may be cause for the denial of my application.

☑ b. I agree that the Maryland Board of Physicians (the Board) may request any information necessary to process my application for renewal from any person or agency, including but not limited to former and current employers, government agencies, the National Practitioners Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent releases for information that may be requested by the Board.

☑ c. I shall inform the Board, by certified mail, return receipt requested, within 30 days of: (a) action that would be grounds for disciplinary action under Md. Code Ann. Health Occ. §14-404, that occurred at any time during the application period; (b) change in any answer that was originally given in this application.

☑ d. Check Here if you wish to have the option of viewing your completed application online after you renew your license. Otherwise, your application will not be available online for your later viewing. If selected, viewing is available until 12/1/2014.

29. Please provide your electronic signature (type your name) below:

Name: David Chang

Today's Date: 9/3/2014

Last four digits of Social Security Number:

30. Select a Payment Option here to complete your application.

Please note: Credit cards may be used for online payment only. If you or a 3rd party is sending in payment, it must be by check.

Your renewal fee is:

PAYMENT

APPLICATION COMPLETION INFORMATION:

Date Application Started	7/15/2014
Date Application Submitted	9/3/2014
Confirmation Number	
Payment Method	
Amount Paid	
Credit Card Approval No.