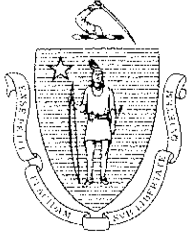

Commonwealth of Massachusetts
Board of Registration in Medicine

200 Harvard Mill Square, Suite 330
Wakefield, Massachusetts 01880
(781) 876-8200

www.mass.gov/massmedboard
Enforcement Division Fax: (781) 876-8381
Legal Division Fax: (781) 876-8380
Licensing Division Fax: (781) 876-8383

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Physician Member

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Physician Member

October 21, 2015

T. Redmond

Re: Public Record Request Concerning Anna T. Contomitros, M.D.

Dear T. Redmond:

This is in regard to a request of October 13, 2015 for records held by the Board of Registration in Medicine ("Board"). Specifically, you request copies of records concerning all complaints, disciplines, lawsuits, applications and reapplications, references, resume and everything in the file for Anna T. Contomitros, M.D.

Enclosed please find 36 pages of documents that are responsive to your request and subject to disclosure under the Public Records Law. Portion of these documents have been redacted as they are exempt from disclosure under M.G.L. c. 4, section 7, clause 26 (a)personal data the disclosure of which is protected by statute.

Pursuant to M.G.L. c. 66, section 10 and 950 CMR 32.08, you may appeal the Board response within 90 days to the Supervisor of Public Records in the Office of the Secretary of the Commonwealth.

Sincerely,

Zoraida Montes

Zoraida Montes
Public Information Coordinator

Enclosure

CCODE OF MASSACHUSETTS REGULATIONS
TITLE 950: OFFICE OF THE SECRETARY OF THE COMMONWEALTH
CHAPTER 32.00: PUBLIC RECORDS ACCESS
Current through December 28, 2007, Register #1094

32.08: Appeals

(1) Denial by Custodian. Where a custodian's response to a record request made pursuant to 950 CMR 32.05(3) is that any record or portion of it is not public, the custodian, within ten days of the request for access, shall in writing set forth the reasons for such denial. The denial shall specifically include the exemption or exemptions in the definition of public records upon which the denial is based. When exemption (a) of M.G.L. c. 4, § 7, clause Twenty-sixth is relied upon the custodian shall cite the operational statute(s). Failure to make a written response within ten days to any request for access shall be deemed a denial of the request. The custodian shall advise the person denied access of his or her remedies under 950 CMR 32.00 and M.G.L. c. 66, § 10(b).

(2) Appeal to the Supervisor. In the event that a person requesting any record in the custody of a governmental entity is denied access, or in the event that there has not been compliance with any provision of 950 CMR 32.00, the requester may appeal to the Supervisor within 90 days. Such appeal shall be in writing, and shall include a copy of the letter by which the request was made and, if available, a copy of the letter by which the custodian responded. The Supervisor shall accept an appeal only from a person who had made his or her record request in writing. An oral request, while valid as a public record request pursuant to 950 CMR 32.05(3), may not be the basis of an appeal under **950 CMR 32.08**.

It shall be within the discretion of the Supervisor whether to open an appeal concerning a request for public records.

The Supervisor may decline to accept an appeal from a requester where the public records in question are the subjects of disputes in active litigation, administrative hearings or mediation.

The Supervisor may decline to accept an appeal from a requester if, in the opinion of the Supervisor, the request is designed or intended to harass, intimidate or assist in the commission of a crime.

The Supervisor may decline to accept an appeal from a requester if, in the opinion of the Supervisor, the public records request is made solely for a commercial purpose.

Appeals in which there has been no communication from the requester for six months may be closed at the discretion of the Supervisor.

(3) Disposition of Appeals. The Supervisor shall, within a reasonable time, investigate the circumstances giving rise to an appeal and render a written decision to the parties stating therein the reason or reasons for such decision.

(4) Presumption. In all proceedings pursuant to 950 CMR 32.00, there shall be a presumption that the record sought is public.

(5) Hearings. The Supervisor may conduct a hearing pursuant to the provisions of 801 CMR 1.00. Said rules shall govern the conduct and procedure of all hearings conducted pursuant to **950 CMR 32.08**. Nothing in **950 CMR 32.08** shall limit the Supervisor from employing any administrative means available to resolve summarily any appeal arising under 950 CMR 32.00.

(6) In-camera Inspections and Submissions of Data. The Supervisor may require an inspection of the requested record(s) *in camera* during any investigation or any proceeding initiated pursuant to **950 CMR 32.08**. The Supervisor may require the custodian to produce other records and information necessary to reach a determination pursuant to **950 CMR 32.08**.

The Supervisor does not maintain custody of documents received from a custodian pursuant to an order by this office to submit records for an *in-camera* review. The documents submitted for an *in-camera* review do not fall within the definition of public

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records. *See*M.G.L. c. 66, § 10(a) (2002 ed.).

Any public record request made to this office for records being reviewed *in-camera* would necessarily be denied as the office would not be the custodian of those records. *See*950 CMR 32.03 (defining "custodian" as the government employee who in the normal course of his duties has access to or control over records).

Upon a determination of the public record status of the documents, they are promptly returned to the custodian.

(7) Custodial Indexing of Records. The Supervisor may require a custodian to compile an index of the requested records where numerous records or a lengthy record have been requested. Said index shall meet the following requirements:

(a) the index shall be contained in one document, complete in itself;

(b) the index must adequately describe each withheld record or deletion from a released record;

(c) the index must state the exemption or exemptions claimed for each withheld record or each deletion of a record; and,

(d) the descriptions of the withheld material and the exemption or exemptions claimed for the withheld material must be sufficiently specific to permit the Supervisor to make a reasoned judgment as to whether the material is exempt. Nothing in **950 CMR 32.08** shall preclude the Supervisor from employing alternative or supplemental procedures to meet the particular circumstances of each appeal.

(8) Conferences. At any time during the course of any investigation or any proceeding, to the extent practicable, where time, the nature of the investigation or proceeding and the public interest permit, the Supervisor, may order conferences for the purpose of clarifying and simplifying issues and otherwise facilitating or expediting the investigation or proceeding.

The Supervisor does not maintain custody of documents received from a custodian pursuant to an order by this office to submit records for an *in-camera* review. The documents submitted for an *in-camera* review do not fall within the definition of public records. *See*M.G.L. c. 66, § 10(a) (2002 ed.).

Any public record request made to this office for records being reviewed *in-camera* would necessarily be denied as the office would not be the custodian of those records. *See*950 CMR 32.03 (defining "custodian" as the government employee who in the normal course of his duties has access to or control over records).

Upon a determination of the public record status of the documents, they are promptly returned to the custodian

<General Materials (GM) - References, Annotations, or Tables>

Mass. Regs. Code tit. 950, § 32.08, 950 MA ADC 32.08

950 MA ADC 32.08
END OF DOCUMENT

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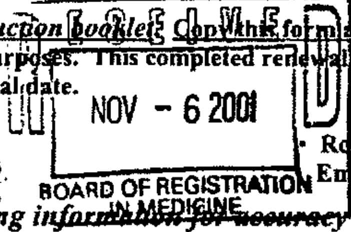
Commonwealth of Massachusetts Board of Registration in Medicine COMPLETED
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

Physician Registration Renewal Application

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



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

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

REDACTED COPY

1. Current Status: Active   Registration No.: 73988   Renewal Date: 11/12/2001

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

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

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

3. A) Mailing/Business Address:
Anna T Contomitros
c/o Maria Mantzouranis
15 Gavriilidou Street
Patissia Athens, 11141

B) Home Address:

Home Phone:

Business Phone: (781)891-1715

Please make corrections (type or print)

Other Name(s): ______

Mailing Address: Annatude, Anna T Contomitros MD
City/Town: 18 Ahaiou Street, Kolonaki, Athens   State: Athens
Zip: ______ Country: GREECE

Business Address: Annatude, Anna T Contomitros MD
City/Town: 18 Ahaiou St, Kolonaki   State: Athens
Zip: ______ Country: GREECE
Business Telephone: (011)(301) 7233-892

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

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

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

c) SS#:

5. a) Name of Medical School:
George Washington Univ Sch of Med & Health Science
b) Year Graduated: 1987   c) Degree: M.D.

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

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

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

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

9. a) Other states where you are now licensed to practice (Abbr.)
CA, NV, GA
b) States where you were previously licensed (Abbr.)
CA, NV, GA

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

Facility Code: 999/✓ (AP) 50 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): Central Clinic of Athens, Athens GREECE
"Kentriki Kliniki Athinon" Athens GREECE

73988

PRINT YOUR LAST NAME: CONTOMITROS LICENSE NUMBER: ______

11. My medical malpractice insurance is covered by a) ☐ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Not Applicable Alternatively, indicate as follows:

I do not carry Malpractice Insurance as I am not now practicing in U.S.A.

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☑ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: Working currently overseas

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

13. A. What is your principal work setting? (See Table 4) 1 5
B. Care of patients in Massachusetts (see instruction booklet). N/A
1) Average weekly hours involved in: a) outpatient care _____ hrs/wk b) inpatient care _____ hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? _____%

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

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

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

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☑ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

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

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

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

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

Signature: [signature] Date: 11/05/2001

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

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

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

I. PHYSICIAN INFORMATION

ANNA THEMIS — CONTOMITROS

First Name | *Middle Initial* | *Last Name* | *Suffix*

Make changes to name here

Mass License # 73988
License Status Active

First Issue Date 05/01/91

Bringham & Women's Hosp.
75 Francis Street
Boston, MA 02115
U.S.A.
(617) 774-0949

Hospital Affiliation

Brigham & Women's Hospital

Make address corrections here:

Make any corrections to above here:

Insurance Plan Affiliation:

CRICO

Licenses Held in Other States:

(Please correct as necessary)

Accepting New Patients? ☑ Yes ☐ No

Accept Medicaid? ☐ Yes ☐ No

II. EDUCATION & TRAINING

Medical School	*Degree*	*Date*
George Washington Univ Sch of Med & Health Science	MD	87

Make corrections here

Residency Program(s)	*Start*	*End*
Beth Israel Hospital	1988	1992

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action

VI. CRIMINAL CONVICTIONS

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

VII. MALPRACTICE

Details of claims paid for Dr. CONTOMITROS

No. of Years in Practice: # 8
4: Residency
4: Attending

Date	Amount Paid	Basis for Complaint
	0.0000	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, Honors	Publications
- Diamond Award 1994 HCHP-Quincy	
- Service Excellence 1994-1995 HCHP-Quincy	

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

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

Registration No.	Status	Fee	Renewal Date	Late Fee
73988	ACTIVE	$250.00	11/12/95	$25.00

Mailing Address:
ANNA THEMIS CONTOMITROS, M.D.

Corrections of Mailing Address
Address (Mailing):
City/Town:
State:
Country:

RECEIVED OCT 02 1995 BOARD OF REGISTRATION IN MEDICINE

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

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

For Office Use Only
M.R.
Pr.
Rc.D.

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:
2. Home Address:
3. Date of Birth: Sex: F
   Lic. Issue Date: 05/01/91 SS#:

   Home Phone   Business Phone
   (617)774-0949
4. Name of Medical School:
   George Washington Univ Sch of Med & Health Science
   Year Graduated: 87 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr):
   b) States where you previously were licensed to practice (Abbr):
6. Specialty Code(s) (See Table 1):
   Code Hours per Week in Mass.
   OBG 0 Obstetrics and Gynecology
7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: OG Code:
8. Drug license number(s), if any: a) Federal (DEA) b) Massachusetts
9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ____

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

Corrections of Pre-Printed Information

Name:
Address:
City/Town:
State: Zip:
Country:

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

Code   Hours per Week in Mass.
        64
If OS, print specialty:

Code: Code:

Federal (DEA):
Mass.:

PRINT NAME AND NUMBER: Physician Last Name: CONTOMITROS Registration Number: 73988

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

Facility Code: 9 2 1 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

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

If 999, print name(s): ______

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

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

If 999, write name(s): ______

11. My medical malpractice insurance is covered by (a) Insurance Carrier ✓ (b) Letter of Credit ___ If applicable, check one.

List Insurer: GRICO

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

State how otherwise exempt: ______

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

13. a) What is your principal work setting? (See Table 4) 4 0

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 40 hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 24 hrs/wk

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

Questions ***14 through 24*** *refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide details on* Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, *whether or not a lawsuit was filed in relation to the claim?*		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes ✓ No, waiver requested ______ No, training program exemption (see instruction booklet). ______

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

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

Signature: ______ Date: 9/27/95

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

Registration No.	Status	Fee	Renewal Date	Late Fee
73988	ACTIVE	$250.00	11/12/93	$25.00

Mailing Address:
ANNA THEMIS CONTOMITROS, M.D.

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

Directions: Staple check to bottom of form. Add late fee if necessary.

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

For Office Use Only
M.R. OCT 05 1993
Pr. CK
Bk/D.E.

Pre-Printed Information

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

   b) Address (Business):
   330 BROOKLINE AVENUE
   DEPT. OF OB/GYN
   BOSTON, MA 02215
3. Date of Birth: Sex: F
   Lic. Issue Date: 05/01/91 SS#:
   Telephone Number:
   Home
   Business
   (617)524-7840
4. Name of Medical School:
   George Washington Univ Sch of Med & Health Science
   Year Graduated: 87 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr):
   b) States where you previously were licensed to practice (Abbr):
6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology
	0	

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
   Code: Code:
   b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
   Code: Code:
8. Drug License Number(s), if any: a) Federal (DEA) b) State (MA)

Corrections of Pre-Printed Information

Name:
Address (Home):
City/Town:
State: Zip:
Country Code: If 999 print Country:
Address (Business): Brigham and Womens Hospital
City/Town: 75 Francis St, Boston MA 02115
Country Code: If 999 print Country:

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:
Telephone Number:
Home: Business: (617) 774-0949
Full Name of Medical School:
Year Graduated: Degree (MD/DO):

Code	Hours per Week in Mass.

If OS, print specialty:

Code: Code:
Code: Code:
Federal (DEA):
State (MA):

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

Staple Check Here

→ one was my last yr of Residency
→ and " " 1st yr of work.

EN

PRINT NAME AND NUMBER: Physician Last Name: Anna Contomitros Registration Number: 73988

10. **Activity Status:** I am applying to be registered with the following status: Active ✓ Inactive ___
 - **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT ___ If applicable, check one.
 List Insurer: CRICO

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

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
 Facility Code: 9 2 1 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
 Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
Facility Code: 0 6 9 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 2 0

 b) Care of patients in Massachusetts (MA) (See instruction booklet.)
 i) How many hours per typical week are you currently involved in *outpatient* care in MA? 30 hrs/wk in MA
 ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 25 hrs/wk in MA

Questions 15 through 23 refer <u>to the past two years only.</u> Check either YES or NO (NOT N/A) to each question. Provide details on Form 15A for all YES answers. <u>Refer to the instruction booklet for additional information.</u>

IN THE PAST TWO YEARS:

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

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

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

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

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

Signature: [signature] Date: 9 25, 93

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

Registration No.	Status	Fee	Renewal Date
73988	ACTIVE	$150	11/12/91

Dr. ANNA THEMIS CONTOMITROS

For Office Use Only
M.R.
Pr.
Bk.
Ch.
D.E.

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

Activity Status:
I am applying to be registered with the following status: Active ✓ Inactive____
I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information

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

2. a) Address (Home):

2. b) Address (Business):

3. Date of Birth: Sex: F
Lic. Issue Date: 05/01/91 SSN
Telephone Number:
Home Business
(617)524-7840

4. Medical School Code: DC001 Year Graduated: 87 Degree: MD
Name of School:
George Washington Univ Sch of Med & Health Science

5. a) Other States where you are now licensed to practice (*Abbr*): N/A
b) States where you previously were licensed to practice (*Abbr*): N/A

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

Code	Hours per Week in Mass.
	0
	0

7.a) Are you American Specialty Board Certified? (Y/N) N
Code:
Code:
7.b) If YES, Enter Codes:
Code:____
Code:____

Corrections of Pre-Printed Information

Name:____
Address:____
City/Town____
State:____ Zip:____
Country Code:____ (If 999 write Country):____
Address: 330 Brookline Ave
City/Town: OBGYN
State: Boston Zip: 02215
Country Code:____ (if 999, write Country):____

Date of Birth (M/D/Y): ___/___/___ Sex (M/F): ___
Lic. Issue Date(M/D/Y): ___/___/___ SSN #: ____
Home: (___)____ Business: (___)____
School Code:____ Year Graduated:____ Degree (MD/DO):____
If 99999, write School:____

Code / Hours per Week in Mass.
If OS, write specialty:____

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

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

30M - 9/90 - P813971

[For Office Use Only: Waiver Granted____ Date:___/___/___]

FILL IN NAME AND NUMBER:
Physician Last Name: Anna Thomis Contomitros   Registration No.: 13988

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

List Insurer: GRIC

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:
(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:______ (ii) OTHERWISE EXEMPT:______

(State how otherwise exempt):______

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

Facility Code: 59 /__(AP) Facility Code: ___ /__(AP) Facility Code: ___ /__(AP)

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

If 999, write Name(s):______

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

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

If 999, write Name(s):______

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)
   a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes ✓ No____ (Check one.)
   b) If you are in a MA program, are you a i) Resident ✓ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)
   c) How many hours per typical week do you spend in this MA post-graduate training program? ≥100 hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)
   a) How many hours per typical week are you currently involved in *outpatient* care in MA? 10 hrs./wk. in MA.
   b) How many hours per typical week are you currently involved in *inpatient* care in MA? 90 hrs./wk. in MA.

14. Principal Work Setting.
   a) What is your principal work setting? (*See Table 6*) 1 0

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

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

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

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

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

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

Signature: [signature]   Date 11 / 9 / 91

ENDORSEMENT REGISTRATION
NATIONAL BOARD OF MEDICAL EXAMINERS
NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

APPLICATION FOR **ENDORSEMENT** REGISTRATION   Fee — $300 to be submitted

Filed: 022891   For Office Use   Application # 9/12

By: [illegible]

Form of Fee: ✓$300   Certificate # 73988   Date of Issue 5/1/92

Please Print   **SWORN STATEMENT**   Date: 2/21/91

Name: Anna Themis Contomitros (First, Middle, Last)   Address*:

Date of Birth:

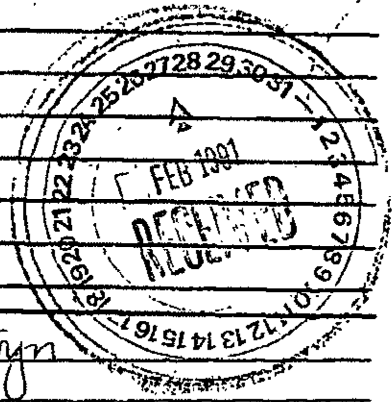
Place of Birth: Aegaleo - Athens Greece   Address valid from: (Dates) - 1993

Name on Birth Certificate: Anna Contomitros   Phone # DAY: 7354700 HOME:

Pre-Medical Education	Medical Education
School: Tufts University / Findlay College	School: George Washington University - Washington DC
Years Attended: 1980 - 1981 / 1978 - 1980	Years Attended: 83 - 87

Postgraduate Education & Hospital Appointments

Place	Position	Dates
Beth Israel Hospital	Senior Ob-Gyn Resident	1990 - 1991
" " "	IInd yr Ob-Gyn "	1989 - 1990
" " "	Int yr Ob-Gyn	1988 - 1989



List all other states in which you have been fully licensed: ϕ

Other names under which you have been licensed: ϕ

List Specialty Boards by which you are certified: ϕ

REASON APPLYING FOR A MASS. LICENSE: to practice OB-Gyn

*NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

AFFADAVIT OF APPLICANT:

I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

(SIGNATURE OF APPLICANT)   Date: 2/21/91

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

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

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Anna P Contomitros

PERMANENT ADDRESS:

LOCAL MAILING: As above

ADDRESS IN (MA): As above

HOSPITAL: Beth Israel Hospital

ADDRESS: 330 Brookline Avenue
Boston Mass 02215

Mailing address valid from:
(dates)________through________

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW. YES NO

1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?
6. Have you ever failed a foreign licensing or certification examination?
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?
9. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?
12. Have you ever, for any reason, lost American Specialty Board Certification?
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? ________
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?
19. * Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions.

Temporary Lisence thru the OB-Gyn department of Beth Israel Hospital

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #19 please follow instructions outlined on Form 1B.

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

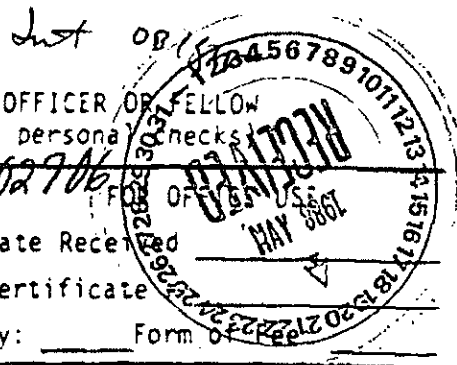
I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for Full Licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this form including Form 1B is true.

SIGNATURE: [signature] DATE 8/21/91

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Inst OB



APPLICATION FOR LIMITED REGISTRATION AS INTERN, MEDICAL OFFICER OR FELLOW
(Fee of $25.00 must accompany application-no currency or personal checks)

FOREIGN MEDICAL GRADUATES MUST SUPPLY A NOTARIZED COPY OF ECFMG CERTIFICATE. IF NO PREVIOUS LIMITED LICENSE HAS BEEN HELD IN MASSACHUSETTS, SUBMIT A NOTARIZED PHOTOCOPY OF THE INTERIM ECFMG CERTIFICATE. A NOTARIZED COPY OF THE STANDARD ECFMG MUST BE SUBMITTED WITH FIRST RENEWAL.

88-02906

L7635

FOR OFFICE USE
Date Received
Certificate
By: _____ Form of Fee

SECTION A: Sworn statement to be completed by applicant. Please type or print.

Name: Anna (First) Themis (Middle) Contomitros (Last)

Mailing Address: _____

Date of Birth: _____

Pre-medical School: Tufts University

Medical School: George Washington University - DC

Have you ever held a previous LIMITED REGISTRATION IN MASSACHUSETTS? _____ (give number, if applicable)

		YES	NO
1.	Have you ever had any medical license revoked, suspended or cancelled?		—
2.	Have you ever been denied a medical license?		
3.	Have you ever been denied the privilege of taking an examination before any State Medical Board?		
4.	Have you ever failed an examination before a State Medical Board?		
5.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		—
6.	Have you ever been warned, censured, had your privileges restricted or been requested to withdraw from a hospital staff?		
7.	Have you ever been a patient for the treatment of a mental illness?		
8.	Have you ever been under treatment for drug dependency or alcoholism?		
9.	Has a judgement ever been returned against you in a malpractice suit?		—
10.	Have you ever been convicted of any criminal offense other than minor traffic offenses?		—

If you answered YES to any of the above questions, please provide a detailed statement.

SIGNATURE OF APPLICANT: Anna Contomitros M.D. DATE: 4/12/88

SECTION B: To be completed and signed by the Superintendent or Administrator of the Hospital in which the applicant has received an appointment.

This certifies that Anna Contomitros, MD has been appointed to the position of Intern inOB/GYN PGY1 in Beth Israel Hospital (Name of Hospital) beginning 7/1/88 and ending 6/30/89.

Is the purpose of this application participation in a training program? yes (yes or no)
If yes, is this program ACGME or RRC accredited? yes (yes or no) If the program is not so accredited (i.e. fellowship), does your institution have an ACGME or RRC accredited residency training program in the applicant's specialty? _____ (yes or no)

SIGNATURE: [signature] OFFICIAL CAPACITY: Vice President, Clinical Services DATE: 5/19/88

ALL INFORMATION SUPPLIED CONSTITUTES A TRUE STATEMENT MADE UNDER PENALITIES OF PERJURY.

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

FOR OFFICE USE ONLY
Limited License Application _____
Pending _____ Approved _____
License # __________

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Anna Themis Contomitros MD
PERMANENT ADDRESS: _
LOCAL MAILING: As above
ADDRESS IN (MA): As above

HOSPITAL: Beth Israel Hospital
ADDRESS: 330 Brookline Avenue
Boston Massachusetts, 02215

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW. YES NO

1. Has any medical malpractice claim ever been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?
3. Have you ever applied for licensure or to sit for an examination or taken an examination, under a different name?
4. Have you ever been denied the privileges of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination since your matriculation in college?
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, or failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?
6. Have you ever failed a foreign licensing or certification examination?
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action?
9. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art? The Board's regulations define "disciplinary action." Please refer to 243 CMR 3.02, attached.
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?
12. Have you ever, for any reason, lost American Specialty Board Certification?
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? __________
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?
19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions.
__________, __________, __________.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

If you have answered "yes" to any of the above except #19 please explain on the reverse side. Attach additional 8 1/2" x 11" sheets if necessary.

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

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

SIGNATURE: Anna Themis Contomitros M.D. DATE: 4/11/88

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.

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

Registration No.: 73988 Renewal Date: 11/12/97 NOV 10 1997

1. Activity Status: (Check only one) ☑ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew
2. Other Name(s), if any, under which you were licensed:
3. A) Mailing/Home Address:
   ANNA THEMIS CONTOMITROS, M.D.

   B) Business Address:

   Home Phone: ( ) -
   Business Phone: ( ) -
4. A) Date of Birth: C) Sex: F
   B) Lic. Issue Date: 05/01/91 D) SS#:
5. A) Name of Medical School:
   George Washington Univ Sch of Med & Health Science
   B) Year Graduated: 87 C) Degree: MD
6. Specialty Code(s) (See Table 1)

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

7. Current American Board of Medical Specialties Certification (See Table 2)
   Code: OG Code:
8. Drug License Numbers, if any:
   A) Federal (DEA):
   B) Massachusetts:
9. A) Other states where you are now licensed to practice
   Abbr:
   B) States where you previously were licensed to practice
   Abbr:

Corrections (type or print)

Other Name(s): ____

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

Other Address: As above
City/Town: ____ State: ____
Zip: ____ Country: ____

Home: (____
Business: (N/A) ____

Date of Birth (M/D/Y): __/__/__ Sex (M/F): ____
Lic. Issue Date (M/D/Y): __/__/__ SS#: ____
Full Name of Medical School: ____

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

Code(s) ____ Hours Per Week in Mass. ____
If OS, Print Specialty: ____

Code: ____ Code: ____

Federal (DEA): ____
Mass: ____

Abbr: ____
Abbr: ____

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

PRINT NAME AND NUMBER: Last Name: Contomitros, Anna Registration Number: 73988

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

Facility Code: ___/✓(AP) Facility Code:___/__(AP) Facility Code:___/__(AP)
Facility Code: CC /✓(AP) Facility Code:___/__(AP) Facility Code:___/__(AP)
If 999, print name(s): ______

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

Facility Code: 921 Facility Code:___ Facility Code:___ Facility Code:___ Facility Code:___

If 999, write Name(s): ______

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

Name of Insurer: ______

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one) a) ✓ Not involved in direct/indirect patient care in Massachusetts b)____ Otherwise exempt

Please explain exemption: ______

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

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

B. *Care of patients in Massachusetts (see instruction booklet).* N/A

1) Average weekly hours involved in: a) outpatient care ______hrs/wk b) inpatient care _____hrs/wk

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

PART A

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

IN THE PAST TWO (2) YEARS:

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

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

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

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

Signature ______ Date: 11/5/97

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

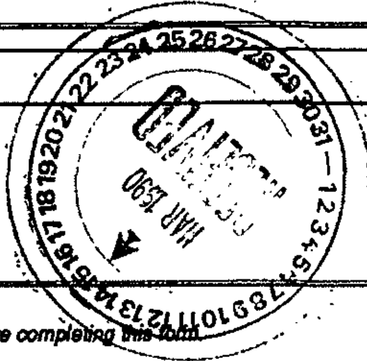
✓ **Renewal** ___ **Change of Program**

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Z13073

Board Use Only:

Registration No.	Status	Fee	Date
		$50	



M.R.		/ /
Pr.		/ /
Bk.	Caug	3/22/90
Ch.		/ /
D.E.		/ /
Fl.		/ /

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. Name (LAST:) CONTOMITROS (FIRST:) ANNA (M.I.:) J
2. Mailing Address: ______
3. Name & Address of Training Hospital: Beth Israel Hospital 330 Brookline Avenue Boston Ma 02215
4. Current Limited License Number: 89-0011-92
5. **Change of Program Applicant:**

   List previous license numbers, Training Institutions and Programs involved:

   N/A

5a. Was previous training a prerequisite for entering into this program ___Yes ✓ No, If no, please attach a explanation detailing your reasons for not completing previous program. In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the Program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: ___Yes ✓ No Program Director's Certification has been requested: ___Yes ✓ No.

6. **Renewal Applicant Only: To be completed by Program Director.**
I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ___Yes x No.

Type or Print Name and Title Henry Klapholz, MD, Director, Residency Training, Dept. of Obstetrics & Gynecology

Signature of Program Director [signature] Date 3/9/90

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Anna Contomitros has been appointed to the position of Intern ___, Resident X, Fellow ___ in Program Obstretics & Gynecology (Program) at Beth Israel Hospital (Institution) beginning 7/1/89 and Anticipated completion date of training 6/30/93.

This program is accredited by the ACGME: Yes X No ___
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ No ___.

Designated Official's Signature: [signature]

Type or Print Name and Title: Malcolm Weiner, Vice President Clinical & Support Services Date 3/12/90

(Applicant See reverse side - You must complete Section C)

FORM 11/89

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate):______________________________

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

Yes No

15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?

16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?

17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?

21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?

23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?

24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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

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

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL__attached pages--is true to the best of my knowledge.

Applicant's Signature: [signature] **Date:** 2/28/90

FORM 11/89

Massachusetts Board of Registration in Medicine Limited License Application, Page 2 of 2

SECTION B: To be completed and signed by the Designated Official of the Institution at which the Applicant has received an appointment.

This certifies that Anna Contomitros has been appointed to the position of PGY 2 in

(Specialty) Obstretrics & Gynecology at Beth Israel Hospital 089

beginning July 1, 1988 and ending June 30, 1992 4/5/89

This program is accredited by the ACGME: Yes X No___
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___ Anticipated completion date of training

program: June 30, 1992

Designated Official's Signature: ______________________

Type or Print Name and Title: ______________________ Date: ________

If renewal, I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? Yes___ No X

Signature of Designated Official [signature]

Type or Print Name and Title: Sandra L. Fenwick Date: 3/21/89
Vice President & Deputy Director

****

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now licensed to practice (Abbreviate): ϕ

12. States where you previously were licensed to practice (This includes Residency Training Licenses) (Abbreviate): ϕ

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your profes[sional activities u]p to the present time, in chronol[ogic]al order. [Pl]ease include employment experiences and training programs. Question 13 applies to me ___ I have attached an explanation: ___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? ___ If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstan[ces u]nder which you left the program. This letter must be sent [directly to the] Board by the Program Director. I have attached an explanation: ___ Program Director's Certification has been requested: ___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?...................................		
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?....................................		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations; See Attached Form 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?..................................		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?..................................		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?..........................		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?..........................		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?..........................		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?..................................		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination, or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?..................................		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?..........................		

****

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Limited License Application, Page 1 of 2

L94:30

Board Use Only:

Registration No.	Status	Fee	Date
		$25	

M.R. ______ __/__/__
Pr.
Bk. Carol 3/23/89
Ch. ______ __/__/__
D.E. ______ __/__/__
Fl. ______ __/__/__

RECEIVED MAR 1989

Important:
. Read the accompanying instructions in their entirety before completing this form.
. Print legibly or type your answers.
. Answer all non-optional questions (front and back of form) completely–**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
. Sign the application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.
. Make a copy of this form and all attachments for your own records–you must give hospitals and other health care facilities copies for credentialing purposes.

Applicants please check one: I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico ____ 2) Graduate of Foreign Medical School ____ 3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ____.

This is a (check one) 1) New Application ____ 2) Renewal ____ If renewal, indicate current Limited License Number ________ 3) Change of Program

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

Applicants please circle one: I will be a PGY1 PGY2 PGY3 PGY4 PGY5 PGY6 PGY7 Other (Specify): ________

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) Contomitros (FIRST:) Anna (M.I.:) Themis

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation): φ

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: φ

2. a) Current Address (Mailing) (Valid Until 1990):

2. b) New Address (Mailing) (Valid After ________):

2. c) Address (Work/Hospital): 330 Brookline Avenue – Beth Israel Hospital Boston Mass

2. d) Telephone (Work/Hospital): (617) 735-4700 Extension b# 2402 2. e) Telephone (Home):

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

6. a) Medical School Name: George Washington University DC 001

6. b) Year Graduated: 1987 6. c) Degree: M.D. ✓ D.O. ___ Other (Specify) ________

6. d) Country: U.S. ✓ State ___ Canada ___ Province ___ If Other *write* Name: ________

7. Specialty: Obstetrics-Gynecology OBG

8. Name of Pre-medical School(s): 08 Tufts University Boston Mass

Location: (City, State, Country) ________

9. Have you ever held a limited license in Massachusetts? Yes ___ No ✓ If yes, list the license numbers you have held and name the institutions involved: Number of Massachusetts limited licenses: ____ Names of the institutions involved and the registration numbers:

10. If you have had any one of the following, please circle which one and attach an explanation to this form: 1) A leave of absence from medical school 2) More than four years of medical school education. Question 10 applies to me: Yes ___ No ✓ I have attached an explanation: Yes ___ No ___

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

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

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

Applicant's Signature: [signature] **Date:** 3/17/89

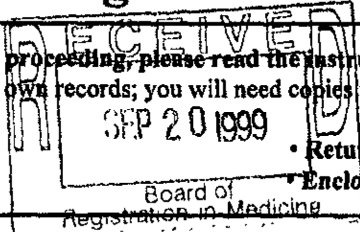
(See reverse side – You must complete Section C)

FORM 1/89

Commonwealth of Massachusetts Board of Registration in Medicine

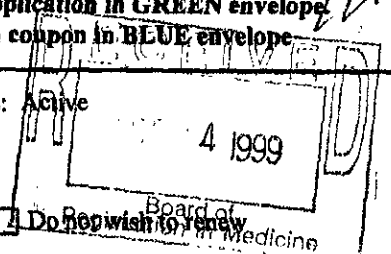
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application



Before proceeding, please read the instruction booklet.

- Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**



Registration No.: 73988 Renewal Date: 11/12/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Business Address:
   ANNA THEMIS CONTOMITROS

   B) Home Address:

   Home Phone:
   Business Phone:

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

5. A) Name of Medical School:
   George Washington Univ Sch of Med & Health Science

   B) Year Graduated: 1987 C) Degree: M.D.

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

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

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

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

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

Please make corrections (type or print)

Other Name(s): ______

Mailing Address: Anna Themis Contomitros
City/Town: ______ State: ______
Zip: ______ Country: ______

Business Address:
Other Address: 195 Worcester Road
City/Town: Wellesley State: Ma
Zip: 02481 Country: U.S.A

Home: ( ) Same!
Business: (781) 263-0033

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

Full Name of Medical School: ______

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

Code(s) ______ Hours Per Week in Massachusetts ______

If OS, Print Specialty: ______

Code: ______ Code: ______

Federal (DEA): ______
Mass: ______

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Contomitros, Anna Registration Number: 8564

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

Facility Code: 75/___ (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%

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

If 999, print name(s): ___

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

Name of Insurer: N/A Alternatively, indicate as follows:

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

a) ☑ Not involved in direct/indirect patient care in Massachusetts b) ☑ Otherwise exempt } b is the reason for a.

Please explain exemption: On Medical leave of Absence 2° Surgery

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

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

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

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

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

N/A now 2° Medical leave 2° Surgery

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

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

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

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

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

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

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

Signature: [signature] Date: 9/15/99

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

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

Physician Registration Renewal Application

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

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

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

1. Current Status: Active Registration No.:73988 Renewal Date:11/12/2003

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

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

NOV 12 2003

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

Please make corrections (print)

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

A) Mailing/Business Address:

3. Anna T Contomitros
Annatude

Mailing Address: 1930 Blackwater Ct
City/Town: Las Vegas State: NV
Zip: 89117 Country: USA

B) Home Address:
Annatude

Billing
New address

Anna T. Contomitros MD

Business Address: 1930 Blackwater Ct
City/Town: Las Vegas State: NV
Zip: 89117 Country: USA
Business Telephone: (702) 360 2218

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

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

Home Phone:

Business Phone:

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

c) SS#:

5. a) Name of Medical School:
George Washington Univ Sch of Med & Health Science

b) Year Graduated: 1987 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	64	Obstetrics and Gynecology
	0	

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

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

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

b) States where you were previously licensed (Abbr.)
CA NV GA

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

Facility Code: 998 ✓ (AP) ___ % Facility Code: 999 ✓ (AP) ___ % Facility Code: ___ (AP) ___ %
Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ %

NOV 19 2003

If 999, print name(s): Dimock Health Center (0%)

998 OUT-OF-STATE
- Lake Mead Hospital Medical Center (Las Vegas, NV) 20%
- Sunrise Hospital (Las Vegas, NV) 30%
- Desert Springs Hospital (Las Vegas, NV) 50%

999 IN-STATE
- Newton-Wellesley Hospital 50%
- Harvard Vanguard Medical Assoc @ Brigham + Women's Hosp. 30%
- Beth Israel Hospital 100%

PRINT YOUR LAST NAME: Contomitros LICENSE NUMBER: 73988

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): Aspen Insurance Policy dates: From: 4/1/03 To: 4/1/04
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☒ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.
☐ Otherwise exempt Please explain exemption: ____

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

13. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: A) inpatient care 0 hrs/wk B) outpatient care 0 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

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

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

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.
CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).
See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

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

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

Signature: ____ Date: 11/4/2003

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

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

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros **License No.:** 73988

09/13/05 S2 42

PART A

1) Current Status: Active **Renewal Due Date:** 10/15/2005 **Birth Date:**

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

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

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ *Check here to change this address*

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

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

5353 West Desert Inn Road, 2124
Las Vegas, NV 89146

Mobile
Phone: (702)221-6372

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address: ____

4) Fax Number: 702-221-6372

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

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

List Certifying Board(s) below: | **Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**

Board Name	ABMS or AOA	Certificate/Subspecialty	Correct?	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☑	☐
			☐	☐
			☐	☐
			☐	☐

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros **License No.:** 73988

09/13/05 S2 43

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

a) Massachusetts:

b) Federal (DEA):

c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

CA NV GA

8b) States where you were previously licensed (Abbr.)

CA NV GA

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

Principal Work Setting: Hospital Change to: ____________

Please enter the *approximate* number of work hours at your principal work setting: 80 hrs

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

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Other	☐	Admitting		80hrs
Out of State Hospital	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: _____ hrs/wk

b) outpatient care 0 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: Change to: ____________

Policy dates: From ___/___/___ To ___/___/___
(required)

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

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

Check one:

☑ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* ____________

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros **License No.: 73988**

09/13/05 S2 44

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

If Yes, please complete Form PCA-O "Office Based Surgery"

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

LIC# 13988

Massachusetts
Board of Registration in Medicine
Physician Profile

This Profile is not available for public release until 06/24/2005.

ANNA T CONTOMITROS MD

I. Physician Information

(The information in sections I - V has been provided by the physician.)

License Status:	Active
License Issue Date:	05/01/1991
Accepting New Patients:	No
Accepts Medicaid:	No
Primary Work Setting:	Hospital
Business Address:	5353 West Desert Inn Road LAS VEGAS, NV 89146
Phone:	(702) 221-6372
Translation Services Available:	None Reported
Insurance Plans Accepted:	Numerous Plans Accepted
Hospitals:	Out of State Hospital Other

Dr. Anna T Contomitros 73988 License Number: 73988

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions.

Under the final HIPAA NPI Rule, all individual and organization covered providers **will be required to obtain an NPI by May 23, 2007.**

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

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

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

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

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

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

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

- [x] My current NPI is: 1659461705
- [ ] I have personally applied for an NPI. (You must provide your NPI number to the Board when received.)
- [ ] I have applied for an NPI using a third party (enter name): ____________ (follow instructions for Option 3)
- [ ] By checking this option and signing the bottom of this page, I hereby authorize the Board to apply for an NPI on my behalf.
- [ ] As an *inactive* physician, I do not wish to obtain an NPI.

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207VG0400X	Ob+Gyn – Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): ∅ Country of Birth (if outside the US): Greece

Gender: ☐ Male ☑ Female

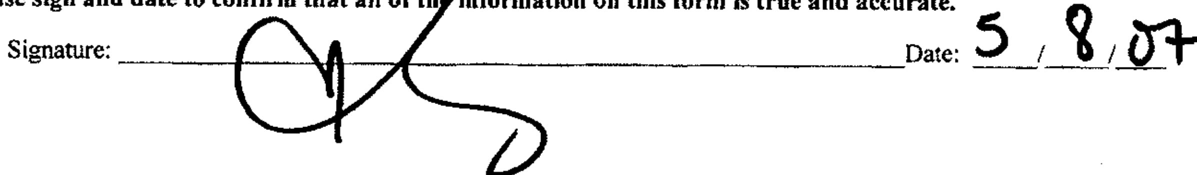
Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

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

Signature:  Date: 5/8/07

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros, M.D. **License No.:** 73988

cmc

PART A

1) Current Status: Active **Renewal Due Date:** 10/15/2007 **Birth Date:**

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

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

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

Please make corrections (print)

2a) MAILING ADDRESS

☑ *Check here to change this address*

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

2b) HOME ADDRESS

Phone:

☑ *Check here to change this address*

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

Home address cannot be a Post Office Box

RECEIVED NOV 14 2007 Board of Registration in Medicine

2c) BUSINESS ADDRESS
5353 W. Desert Inn Road
Suite #2073
Las Vegas, NV 89146

Phone: (702)221-6372

☐ *Check here to change this address*

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

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: (702)221-6372

Correct your E-mail and Fax Number below:

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

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

List Certifying Board(s) below: / **Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**

Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros, M.D. **License No.: 73988**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: ______

b) Federal (DEA): ______

c) Federal (DEA) XS: ______

Please make corrections as necessary

8) Other states where you are now licensed to practice

CA NV GA

9) States where you were previously licensed

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	**Location (City or Town)**	**State**	**Delete?**
Other			☐
Out of State Hospital			☐
			☐
			☐
			☐

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

Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: ____ hrs/wk

b) outpatient care 0 hrs/wk Change to: ____ hrs/wk

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

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

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

Current Insurance Carrier: BHS Insurance Co., LTD Change to: ______

Policy dates: From __/__/__ To __/__/__

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: ______

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

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

Massachusetts Physician Renewal Application

Physician Name: Anna T Contomitros, M.D. **License No.: 73988**

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Physician Name: Anna T Contomitros, M.D. **License No.: 73988**

PART C

Check One: **PHYSICIAN PROFILE**

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

CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: ____________________ Date: 11 / 7 / 07

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Anna T Contomitros, M.D. **License No.:** 73988

Current Status: Active **License Expiration Date:** 11/12/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

3599 south eastern avenue
Las Vegas
Nevada - 89169
United States of America

Home Address:

Business Address:

3599 south eastern avenue
Las Vegas
Nevada - 89169
United States of America
(702) 531-5400 - 100

3) **Email Address:**

4) **Fax Number:** (702) 731-5404

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
California
Nevada

9) **States where you were previously licensed**
Georgia

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

WorkSite	Location
Other	

Out of State Hospital

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

12) Medical Liability Insurance Information

I am not required to have malpractice insurance.

Not involved with direct or indirect patient care in Massachusetts.

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

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Anna T Contomitros, M.D. **License No.:** 73988

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

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

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