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

Rec'd 9/7/01 COMPLETED

# Physician Registration Renewal Application

RECEIVED SEP - 7 2001 Board of Registration in Medicine

REDACTED COPY

**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.***

1. Current Status: Active Registration No.: 210324 Renewal Date: 09/06/2001

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:
Jennifer Childs-Roshak

B) Home Address:

Home Phone:

Business Phone: 508-860-7899

**Please make corrections** (type or print)

Other Name(s): _____

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

Business Address: Jennifer Childs-Roshak, MD
City/Town: Family Health Ctr 26 Queen St State: MA
Zip: Worcester Country: 01610
Business Telephone: (508-) 860-7899

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: Temple University School of Medicine
b) Year Graduated: 1993 c) Degree: M.D.

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

| Code(s) | | Hours per Week in Mass. |
|---|---|---|
| FP | Family Practice | 40hrs |

7. Current American Board of Medical Specialties Certification (See Table 2)
1st 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.)
ME (exp 9/30/02) ___ ___ ___

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

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

Facility Code: S33/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
Facility Code: ___/___ (AP) ____ % Facility Code: ___/___ (AP) ____% Facility Code: ___/___ (AP) ____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: CHUDS-ROSHAK LICENSE NUMBER: 210324

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: Promutual Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption:

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

13. A. What is your principal work setting? (See Table 4) 2 5

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

1) Average weekly hours involved in: a) outpatient care 12 hrs/wk b) inpatient care 4 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 30 %

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

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

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

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

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

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

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

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

Signature: Date: 9/2/01

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

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

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

Application #: 210324
Date of Issue: _____

**Commonwealth of Massachusetts - Board of Registration in Medicine**
**10 West Street, 3rd Floor**
**Boston, MA 02111 - (617) 727-3086**

# 2767 Glenn 4/12/01

# FULL LICENSE APPLICATION

**Application Fee:** Please enclose a check or money order in the amount of $350 made payable to the Commonwealth of Massachusetts.

**Check One:** ☑ U.S./Canadian Graduate ☐ International Graduate

**Legal Name** (do not use nicknames or initials, unless they are part of your legal name)

CHILDS-ROSHAK JENNIFER
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____

**Other Name(s) Used** - List any other name(s) you have used which may appear on your identifying documents, such as medical education and examination records. If not applicable, check here ☐

Entire Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: BURLINGTON VT USA
City State/Province/Territory Country if not USA

Home Address: _____ (until 3/29/01)
Number and Street

City State/Province/Territory Zip (or postal) Code

Past Business Address: 272 Congress ST
Number and Street

PORTLAND ME 04101
City State/Province/Territory Zip (or postal) Code

Business Telephone: (207) 874-2466, ext. - Home Telephone: _____

Preferred Mailing Address: ☐ Business Address ☑ Home Address

APPLICANT'S NAME: Jennifer Childs-Roshak, MD

**Pre-medical School**

Facility: Harvard University Degree: BA From 1/82 To 1/86
Street: _____ City: Cambridge State: MA

Facility: Bryn Mawr College Degree: MA 1/87 1/88
Street: (premed program) City: Bryn Mawr State: PA

**Medical School**

Facility: Temple University Degree: MD From 1/89 To 1/93
Street: _____ City: Philadelphia State: PA

Facility: _____ Degree: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Date of medical school graduation: 1993

Note: U.S. graduates must include a written explanation for the duration of medical education longer than four (4) years, and for any breaks in medical education. International graduates must provide a written explanation for the duration of medical education longer than six (6) years and any breaks in medical education.

**Postgraduate Education:**

List all postgraduate training chronologically from medical school to the present, the name and address of the facility, your position, e.g. PGY 1, 2, fellow, etc. and dates of affiliation. You must account for all periods of training or postgraduate work from the time you graduated from medical school.

Facility: Maine Medical Ctr - FP program Position: PGY-1→3 From 7/1/93 To 6/30/96
Street: Bramhall St City: Portland State: ME

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ __/__/__ __/__/__
Street: _____ City: _____ State: _____

APPLICANT'S NAME: Jennifer Childs-Roshak, MD

**Hospital Affiliations and Employment**

List hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training, in chronological order. Also include periods of unemployment or employment outside of medicine. Attach a separate sheet of paper if necessary.

| | | | From | To |
|---|---|---|---|---|
| Facility: Maine Medical Ctr | Position: attending | | 7/96 | present |
| Street: Bramhall St | City: Portland | State: ME | | |
| Facility: Mercy Hospital | Position: attg. phys. | | 7/96 | present |
| Street: State St | City: Portland | State: ME | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |

1. List other states (abbreviations) where you are currently or have ever been licensed: ME
2. Are you certified by the American Board of Medical Specialties? ☑ Yes ☐ No
3. List Board Certification(s): FP Board certified - 1997
4. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Moving to Mass. 4/1/01 - family job change
6. Name of Facility: none yet
7. Address: City:
8. Anticipated starting date in Massachusetts: 7/1/01

**Affidavit of Applicant**

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

Signature of Applicant

2/26/01
Date

**Commonwealth of Massachusetts Board of Registration in Medicine**
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086



## STATE LICENSE VERIFICATION

***Applicant's Instructions:*** Complete the waiver for release of information and forward this form to every state board where you are currently licensed or were licensed in the past.

***Applicant's Waiver for Release of Information:***

I am applying for licensure in the Commonwealth of Massachusetts and the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. I hereby authorize the release of any information in your files, favorable or otherwise.

Signature of physician: _____ Date: 2/26/01

Print or type name: JENNIFER CHILDS BUSHAK, MD

License number: _____ Status of license: ☑ Active ☐ Inactive ☐ Other _____

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***TO BE COMPLETED BY STATE BOARD***

1. Name of medical school of graduation: _____
2. Date of graduation: ___/___/___ License number: _____ Date of issue: ___/___/___
3. Basis for licensure: _____
   Name(s) of medical licensing examinations(s).
4. Expiration date of license: ___/___/___
5. Status of license: (*check one*) ☐ good standing ☐ revoked ☐ suspended
6. If revoked or suspended, please explain: _____

| | YES | NO |
|---|---|---|
| 7. Has the licensee ever been on probation? | ☐ | ☐ |
| 8. Has the licensee ever been requested to appear before the board? | ☐ | ☐ |

If "yes," please explain: _____

Other derogatory information: _____

Remarks: _____

*BOARD SEAL*

Signed: _____

Print Name: _____

Title: _____

State Board: _____ Date: ___/___/___

***PLEASE RETURN DIRECTLY TO THE MASSACHUSETTS BOARD OF REGISTRATION***

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

# MALPRACTICE HISTORY

**Applicant's Instructions:** Complete this waiver for release of information and forward a copy to each of your current and past liability carrier(s) over the past ten (10) years. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. Please return the form(s) with your original signature to the Board of Registration in Medicine.

**Waiver for Release of Information**

I authorize my professional liability carrier(s) listed below to release to the Commonwealth of Massachusetts, Board of Registration in Medicine, my malpractice history and any and all claims or actions for damages, including the following:

1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier.

**NOTE: IF THE APPLICANT HAS ANY OPEN OR CLOSED CASES WHERE MONIES HAVE BEEN PAID, A COPY OF THE COMPLAINT OR SUMMONS, DISPOSITION OR JUDGEMENT AND AMOUNT OF MONIES PAID ON BEHALF OF THE APPLICANT MUST BE FOWARDED DIRECTLY TO THE BOARD.**

**Dates of Issue**

Liability Carrier: Maine Medical Mutual **From:** 7/93 **To:** Present
City: Portland State: ME
Policy Number: _____

Liability Carrier: _____ **From:** ___/___ **To:** ___/___
City: _____ State: _____
Policy Number: _____

Liability Carrier: _____ **From:** ___/___ **To:** ___/___
City: _____ State: _____
Policy Number: _____

**Please forward the information requested to the Board of Registration in Medicine at the address above.**

**Signed:** _____ 2/26/01
**Date**

**Print Name:** Jennifer Childs-Roshak, MD

# SUPPLEMENT FORM

**Name:** Jennifer Childs-Roshak, MD **Date:** 2/26/01

**IMPORTANT NOTE: If you answer "yes" to any of these questions, you must provide the additional information on pages 4-10.**

| | | YES | NO |
|---|---|---|---|
| 1. | Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution? | | |
| 2. | Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training? | | |
| 3. | Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name:_____ | | |
| 4. | Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination? | | |
| 5. | Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body? | | |
| 6-A. | Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure? | | |
| 6-B. | Have you ever voluntarily surrendered a license to practice medicine or any healing art? | | |
| 7. | Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards? | | |
| 8-A. | Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition). | | |
| 8-B. | Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association ( national, state or local)? | | |

**Print Name:** Jennifer Childs-Roshak, MD

| | | YES | NO |
|---|---|---|---|
| 9-A. | Have you ever voluntarily relinquished any medical staff membership? | | --- |
| 9-B. | Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board? | | |
| 9-C. | Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body? | | |
| 9-D. | Have you ever, for any reason, withdrawn an application for hospital privileges or appointment? | | |
| 10. | Have you ever been charged with any criminal offense, other than a minor traffic offense? | | |
| 11. | Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges? | | |
| 12. | Has any professional liability insurance provider ever 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 ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider? | | |
| 13. | Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or third party programs? | | |
| 14. | Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan? | | |
| 15-A. | In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | | |
| 15-B. | In the past ten (10) years, 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 has such a suit been settled, adjudicated or otherwise resolved? | | |

**Applicant's Signature:** Jennifer Childs-Roshak **Date:** 2/26/01

JENNIFER CHILDS-ROSHAK, MD 393

MEDICAL EDUCATION VERIFICATION

**Commonwealth of Massachusetts Board of Registration in Medicine**
**10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086**

# MEDICAL EDUCATION VERIFICATION

RECEIVED
APR 13 2001
Office of Faculty & Student Records
TEMPLE UNIVERSITY
SCHOOL OF MEDICINE

**APPLICANT INSTRUCTIONS:** Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

## Waiver for Release of Information

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution to the ***Massachusetts Board of Registration in Medicine.***

Applicant's Signature: [signature] Date of Birth: ____ Social Security No: ____

Name of Medical School: Temple University School of Medicine

Address: Broad & Ontario Streets City: Philadelphia State or Province: PA 19140

RECEIVED
APR 25 2001
Board of Registration in Medicine

**INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL**

**Please complete this form and forward it, together with a copy of the applicant's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) directly to the Board of Registration in Medicine.**

**APPLICANT'S EDUCATIONAL HISTORY**

If name of institution was different from the above named institution when applicant attended, please enter name below:

**Premedical Education:** Does your school have a premedical school education requirement? ☐ Yes ☐ No

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Harvard University / Pre-med → Bryn Mawr College

Undergraduate School Address: Cambridge MA / Bryn Mawr, PA

Continued on back

**MEDICAL EDUCATION VERIFICATION**

**Enrollment and Participation:** Our records indicate that

CHILDS-ROSHAK, JENNIFER

(type/print applicant's name: last, first, middle, suffix)

attended our medical school on the following dates (*indicate the month, day and year in the section below*):

| **ATTENDANCE DATES:** | **FROM** | **TO** | **FROM** | **TO** |
|---|---|---|---|---|
| | 09 / 05 / 89 | 06 / 08 / 90 | 06 / 01 / 92 | 05 / 20 / 93 |
| | 08 / 20 / 90 | 05 / 13 / 91 | / / | / / |
| | 06 / 17 / 91 | 05 / 29 / 92 | / / | / / |

The applicant attended 4 yrs total ~~weeks~~ of continuing on-campus education, not less than 32 weeks in each academic year and

*check one* [X] was awarded a degree in DOCTOR OF MEDICINE on (month/day/year) 05 / 20 / 93

[ ] was NOT awarded degree. Please explain reason(s).

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

| | **YES** | **NO** |
|---|---|---|
| 1. Did the applicant take any leaves of absence or breaks from his/her medical education? | | |
| 2. Was the applicant ever placed on probation? | | |
| 3. Was the applicant ever disciplined or under investigation? | | |
| 4. Were any negative reports ever filed by instructors regarding the applicant? | | |

COMMENTS:

**AFFIX INSTITUTIONAL SEAL HERE**

**(if the institution does not have a seal, this form must be notarized)**

**INTERNATIONAL MEDICAL SCHOOL GRADUATES: ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVISIONAL CERTIFICATE.**

Signature: M. Judith Russo

Print Name: M. Judith Russo

Title: DIRECTOR, OFFICE OF FACULTY AND STUDENT RECORDS

Date: 04 / 18 / 01 Telephone: ( 215 ) 707-2079

POSTGRADUATE VERIFICATION

**Commonwealth of Massachusetts--Board of Registration in Medicine**
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086

# POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below to be forwarded to the Massachusetts Board of Registration in Medicine.

Applicant's Signature: Jennifer Childs-Roshak Date: 2/26/01

Print or Type Name: JENNIFER CHILDS-ROSHAK, MD

Name of Institution: Maine Medical Center, Family Practice Residency Program

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registration in Medicine at the address above. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training to the Board.

Name of Institution: Maine Medical Ctr. FP Residency Program

If name of Institution was different when applicant attended, please enter name:

**Enrollment and Participation:** Our records indicate that JENNIFER CHILDS-ROSHAK, MD (type or print applicant's name) participated in the following program:

| Program Type (internship, residency, fellowship) | PGY (1,2,3,4) | Department (ObG, Internal medicine, etc.) | Dates Attended (MONTH/DAY/YEAR) FROM | TO: | Completed (YES/NO) | Accredited By (ACGME, RSC, AOA or not accredited |
|---|---|---|---|---|---|---|
| Internship | | Family Practice | 7 1 93 | 6 30 ~~94~~ 94 | Yes | |
| + PGY 2-3 | 1 | | 7 1 94 | 6 30 ~~95~~ 95 | Yes | |
| Residency | | | 7 1 95 | 6 30 96 | Yes | |
| | | | / / | / / | | |
| | | | / / | / / | | 5/18/01 |

**POSTGRADUATE VERIFICATION**

Continued on back

**APPLICANT'S NAME:** Jennifer Childs-Roshek, MD

**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

| QUESTIONS | YES | NO |
|---|---|---|
| 1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training? | | |
| 2. Was the applicant ever placed on probation? | | |
| 3. Was the applicant ever disciplined or under investigation? | | |
| 4. Were any negative reports ever filed by instructors regarding the applicant? | | |
| 5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems? | | |
| 6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☑ ACGME ☐ Other: | | |

COMMENTS: _____

**Certification:** I hereby certify that the above information is correct, to the best of my knowledge.

Program Director's Signature: [signature]

Print Name: Skeltys

Academic Title: Assoc Clin Prof UVM

Telephone: (207) 871 2875 Today's Date: 3/21/01

**AFFIX INSTITUTIONAL SEAL HERE**

**(if the institution does not have a seal, this form must be notarized)**

Judith C. Belyea

Judith Gilman
Notary Public, Maine
My Commission Expires
December 3, 2005

**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.: 210324 Renewal Date: 09/06/2003

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

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

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

A) Mailing/Business Address:

3. Jennifer Childs-Roshak

B) Home Address:

Home Phone:

Business Phone: 508-860-7899

**Please make corrections** (print)

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

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

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

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

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

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

c) SS#:

5. a) Name of Medical School: Temple University School of Medicine

b) Year Graduated: 1993 c) Degree: M.D.

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

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| FP | 40 | Family Practice |
| | 0 | |

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

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

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

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

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: 533 ✓ (AP) 1 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: CHILDS-ROSHAK LICENSE NUMBER: 210324

11. My medical malpractice insurance is covered by ☑ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): Mass Mutual Policy dates: From: 7/1/01 To: present
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) 25 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 10 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

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

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

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

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

Signature: [signature] Date: 7/23/03

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak **License No.:** 210324

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/09/2005 **Birth Date:**

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

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

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

**2a) MAILING ADDRESS**

**Please make corrections** (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

☐ *Check here to change this address*

**2b) HOME ADDRESS**

RECEIVED JUL 28 BOARD OF REGISTRATION IN MEDICINE

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___) _____

Phone:

☐ *Check here to change this address*

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**

Blackstone Valley Family Physicians
18 Granite Street
Whitinsville, MA 01588

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Phone: (508)234-6311

☐ *Check here to change this address*

*Business address cannot be a Post Office Box*

**3) E-mail Address:** _____

**4) Fax Number:** 508-234-4815

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **Additional specialties:** |
|---|---|---|
| Family Practice | ☐ | |
| | ☐ | |
| | ☐ | |

**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?** |
| Family Medicine | ABMS | Family Practice | ☑ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak **License No.:** 210324

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

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

Principal Work Setting: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 40

**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 |
|---|---|---|---|---|
| Milford-Whitinsville Regional Hospital | ☐ | Admitting | | 4 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

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

Average weekly hours involved in: a) inpatient care ~~40~~ hrs/wk Change to: 4 hrs/wk

b) outpatient care 10 hrs/wk Change to: 40 hrs/wk

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

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

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

Current Insurance Carrier: ~~ProMutual Group~~ Change to: MLMIC Liab. Mutual

Policy dates: From 9/30/04 To 9/30/05 *(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: Jennifer Childs-Roshak** **License No.: 210324**

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

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

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

| | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<br>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?<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Are there any criminal charges pending against you today?<br>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

PRINT NAME: Jennifer Childs-Roshak LICENSE #: 210324

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Board of Registration in Medicine

07/27/06 32 151

## 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 and has those assigned by health plans, government programs and health care purchasers for the purposes of conducting these business transactions. Under the HIPPA NPI Rule, all individual and organization covered providers will be required to obtain an NPI by May 23, 2007.

**PLEASE SELECT ONE OF THE OPTIONS BELOW:**

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 (see instructions for Option 2).

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

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

☑ My current NPI is: 1 4 9 7 7 8 0 7 7 9

☐ I have personally applied for an NPI.

☐ 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.

## HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) code from the attached pages. The primary provider taxonomy code is required if you authorize BORIM to apply for an NPI on your behalf. Please complete every question before mailing this form to the Board. Thank you.

| | Taxonomy (Specialty) Code | Taxonomy Description (Print) |
|---|---|---|
| Primary Provider Taxonomy: | 2 0 7 Q 0 0 0 0 0 X | Family Practice |
| 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): Vt Country of Birth (if outside the US): _____

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.

**I authorize the Board of Registration in Medicine to provide my NPI to any authorized hospital, health plan or health organization.**

Signature: _____ Date: 7/16/06

**PLEASE MAIL THIS ORIGINAL COMPLETED FORM TO: Board of Registration in Medicine, 560 Harrison Avenue, Suite 4, Boston, Massachusetts 02118.**

# Massachusetts Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

## PART A

**1) Current Status:** Active **Renewal Due Date:** 08/09/2007 **Birth Date:**

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

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

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

**2a) MAILING ADDRESS**

☐ *Check here to change this address*

**Please make corrections** (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

**2b) HOME ADDRESS**

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Board of Registration in Medicine

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**
Blackstone Valley Family Physicians
18 Granite Street
Whitinsville, MA 01588

Phone: (508)234-6311

☐ *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:** (508)234-4215

**Correct your E-mail and Fax Number below:**

_____

_____

| **5) Specialties** *(See Renewal Instructions, page 4.)* | **Delete?** | **List Additional Specialties:** |
|---|---|---|
| Family Practice | ☐ | |
| | ☐ | |
| | ☐ | |

**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?** |
| Family Medicine | ABMS | Family Practice | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name: Jennifer Childs-Roshak, M.D.** **License No.: 210324**

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

**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? |
|---|---|---|---|
| ~~Milford-Whitinsville Regional Hospital~~ → name changed | | | ☐ |
| Milford Regional Medical Center ← | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

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

Average weekly hours involved in: a) inpatient care 4 hrs/wk Change to: _____ hrs/wk

b) outpatient care 40 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: ~~MLMIC~~ CMIC Change to: CMIC

Policy dates: From 6/30/07 To 6/30/08

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: Jennifer Childs-Roshak, M.D.** **License No.: 210324**

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

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

| | YES | NO |
|---|---|---|
| **14) CLAIMS MADE**<br>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).<br>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**<br>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**<br>Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.<br>a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?<br>b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period? | | |
| **17) CRIMINAL CHARGES**<br>a) Have you been charged with any criminal offense during this time period?<br>b) Have any criminal offenses/charges against you been resolved during this time period?<br>c) Are there any criminal charges pending against you today?<br>d) Are any Applications for Issuance of Process pending against you? | | |
| **18) INVESTIGATIONS AND DISCIPLINARY ACTIONS**<br>a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association?<br>b) Have you ever taken a leave of absence from any health care facility, group practice or employer?<br>c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association?<br>d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association? | | |
| **19)** Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency? | | |
| **20)** Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason? | | |
| **21)** Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier? | | |

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

**Physician Name: Jennifer Childs-Roshak, M.D.** **License No.: 210324**

## PART C

**Check One:**

**PHYSICIAN PROFILE**

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

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

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

**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: 7/18/07

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

# Massachusetts Physician Renewal Application

**Physician Name: Jennifer Childs-Roshak, M.D.** **License No.: 210324**

## NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

☑ My current NPI is: 1 4 9 3 7 8 0 7 3 9

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

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

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

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

## HIPAA TAXONOMY CODES

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

| | Taxonomy (Specialty) Code | Taxonomy Description (Print) |
|---|---|---|
| Primary Provider Taxonomy: | 2 0 7 6 0 0 0 0 0 X | Family Practice |
| 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): _____

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: Jennifer Childs-Roshak Date: 7/18/07

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

**Current Status:** Active **License Expiration Date:** 9/6/2009

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**
Milford Regional Medical Center
14 Prospect St
Milford
Massachusetts - 01757
United States of America
(508) 422-2936

3) **Email Address:**

4) **Fax Number:** (508) 634-1540

5) **Specialties**
Family Medicine

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

| ABMS/AOA | Board Name | Certification | Subspecialty |
|---|---|---|---|
| ABMS | Family Medicine | Family Medicine | |

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
None Reported

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

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 |
|---|---|
| Milford-Whitinsville Regional 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?**

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

| | |
|---|---|
| **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?**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

**Current Status:** Active **License Expiration Date:** 9/6/2011

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**
Milford Regional Medical Center
14 Prospect St
Milford
Massachusetts - 01757
United States of America
(508) 422-2936

3) **Email Address:**

4) **Fax Number:** (508) 634-1540

5) **Specialties**
Family Medicine

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

| ABMS/AOA | Board Name | Certification | Subspecialty |
|---|---|---|---|
| ABMS | Family Medicine | Family Medicine | |

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
None Reported

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

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 |
|---|---|
| Milford-Whitinsville Regional Hospital | Milford Regional Medical Center |

**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?

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

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

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

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

| | |
|---|---|
| **22) Have you completed all 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?**

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

**Current Status:** Active **License Expiration Date:** 9/6/2013

**1) Activity Status:** Active

**2) Address & Contact Information**

**Mailing Address:**
Harvard Vanguard Medical Associates
133 Brookline Avenue
Boston
Massachusetts - 02215
United States of America

**Home Address:**

**Business Address:**
Harvard Vanguard Medical Associates
133 Brookline Avenue
Boston
Massachusetts - 02215
United States of America
(617) 421-2634

**3) Email Address:**

**4) Fax Number:** (617) 421-6084

**5) Specialties**
Family Medicine

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

| ABMS/AOA | Board Name | Certification | Subspecialty |
|---|---|---|---|
| ABMS | Family Medicine | Family Medicine | |

**7) Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

**8) Other states where you are now licensed to practice**
None Reported

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

**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 |
|---|---|
| Harvard Vanguard Medical Assoc. Kenmore | Boston |

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 12 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 02/01/2012 | 12/31/2013 | Claims made with tail coverage |

**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?

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**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?

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

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

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

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

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

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

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

# Commonwealth of Massachusetts
# Board of Registration in Medicine
# Physician Renewal Application

**Physician Name:** Jennifer Childs-Roshak, M.D. **License No.:** 210324

**Current Status:** Active **License Expiration Date:** 9/6/2015

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**
Harvard Vanguard Medical Associates
133 Brookline Avenue
Boston
Massachusetts - 02215
United States of America

**Home Address:**

**Business Address:**
Harvard Vanguard Medical Associates
133 Brookline Avenue
Boston
Massachusetts - 02215
United States of America
(617) 421-5804

3) **Email Address:**

4) **Fax Number:** (617) 421-2040

5) **Specialties**
Family Medicine

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

| ABMS/AOA | Board Name | Certification | Subspecialty |
|---|---|---|---|
| ABMS | Family Medicine | Family Medicine | |

7) **Drug License Numbers**

| Massachusetts | Federal (DEA) | Federal (DEA) XS |
|---|---|---|

8) **Other states where you are now licensed to practice**
None Reported

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

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 |
|---|---|
| Harvard Vanguard Medical Assoc. Kenmore | Boston |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 12 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2015 | 12/31/2015 | Claims made with tail coverage |

**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?

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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 taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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

**22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, 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?**

**25) Electronic Health Records Proficiency**
I have demonstrated proficiency in the use of EHR by participation in a Meaningful Use program as an eligible professional.

**26) Requirement to Complete Training in Recognizing and Reporting Child Abuse**
Have you completed training to recognize and report suspected child abuse or neglect?

# Jennifer Childs-Roshak, MD

## Professional Experience

May 1999 - present

**MMC Family Practice Center,** Portland, ME
Assistant Medical Director, Family Practice Center – Portland site
Assistant Program Director, MMC Family Practice Residency Program.
Family Physician, Casco Bay Family Physicians (faculty group practice)

Active member of management team for 23 provider, 10,000 patient practice. Responsible for recent transition to Open Access scheduling, Learning Resource Center, YMCA outreach program as well as team-specific practice management. Participate on financial subcommittee addressing physician compensation, budget and billing. Actively involved with scheduling systems improvements, procedural training for residents and evaluation of medical service vendors. Academic responsibilities include community medicine curriculum, a school-based teaching program and Community Oriented Primary Care curriculum. Manage 1300+ patient panel with full spectrum of family practice excluding OB (16 clinical hours per week).

January 1998 – present

**University of Vermont Medical School,** Maine Medical Center, Portland, ME
Associate Clinical Professor of Medicine, Department of Family Practice

Supervise and teach 3rd year UVM medical students during clerkships

June 1996-April 1999

**InterMed,** Yarmouth, ME
Family Physician

Family Practice within a large multi disciplinary primary care group. Practice encompassed minor surgical procedures, in-office orthopedics, flexible sigmoidoscopy, colposcopy, OB and gynecologic procedures.

## Additional Experience:

September 1999 – present

**Kids Run Better Unleaded,** Co-Director

Multidisciplinary public health project focussed on increasing provider awareness of lead poisoning, increasing screening rates state wide and coordinating data and public health follow-up of children with elevated lead levels. Project grant funded.

September 1996 – present

**Portland Department of Public Health,** Portland, ME
Committee member, Childhood Lead Poisoning Prevention Committee

Participate in multi-disciplinary, grass roots committee for the prevention of lead poisoning. Activities have included participating in a locally

produced television documentary, giving radio interviews and providing support to the committee. State committee member 1998-1999.

July 1990-July 1993 — **U.S. Public Health Service,** Philadelphia, PA
Commissioned Health Officer

Worked in two-inner city public health clinics while a freshman and senior medical student. Wrote and designed promotional and recruitment materials for a non-profit city health clinic.

September 1986-August 1987 — **United Nations Fund for Population Activities,** New York, NY
Editor/Reports Officer/Speech Writer

Responsible for over 700 pages of program proposals and reports related to international population efforts including maternal and child health, epidemiology and census taking. Wrote speeches for leaders in UNFPA.

## Education:

November 2000 - present — **AAFP Fundamentals of Management course** – year long course on practice management started November, 2000

July 1993-July 1996 — **Maine Medical Center Family Practice Residency,** Portland, ME
Family Practice Internship and Residency

September 1989-June 1993 — **Temple University School of Medicine,** Philadelphia, PA
MD

August 1987-June 1988 — **Bryn Mawr College,** Bryn Mawr, PA
Post-baccalaureate Pre-Medical Program

September 1982-June 1986 — **Harvard University, Radcliffe College,** Cambridge, MA
BA, English
Dean's List 1982-1985
Ames Award for Public Service 1986

## Certification:

1997 - present — American Board of Family Practice
1994 — National Board of Medical Examiners

## Professional Societies:

American Academy of Family Practice
Maine Academy of Family Practice
Society of Teachers of Family Medicine

## Licensure:

Maine
Massachusetts (application in process)

## Outside Interests:

Sailing, skiing, hiking, camping, travel, reading and gardening
School volunteer and youth sport coach (Little League)