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DEC 7 2005

Board of Registration
in Medicine

Application #: 227077
Date of Issue:

#1022
600.
CH

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

## FULL LICENSE APPLICATION

**Application Fee:** Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

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

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

DIXON ANNE BRECKENRIDGE

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

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree________ ☐ Male ☑ Female

**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: Frankfurt GERMANY
City State/Province/Territory Country if not USA

Home Address:
Number and Street

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

Business Address: Wheatridge Medical Offices 4803 Ward Road
Number and Street

Wheat Ridge Colorado 80033
City State/Province/Territory Zip (or postal) Code

Business Telephone: (303) 467-5182, ext. ____ Home Telephone:

E-mail Address:

Preferred Mailing Address: ☐ Business Address ☑ Home Address

PRINT NAME: ANNE BRECKENRIDGE DIXON PAGE 2 OF 3

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Board of Registration in Medicine

**Pre-medical School**

| | | | From | To |
|---|---|---|---|---|
| Facility: Princeton University | Degree: BA | | 9/14/92 | 6/4/96 |
| Street: 101 West College Hall (office of registrar) | City: Princeton | State: NJ | | |
| Facility: | Degree: | | / / | / / |
| Street: | City: | State: | | |

**Medical School**

| | | | From | To |
|---|---|---|---|---|
| Facility: University of Connecticut | Degree: MD | | 8/15/97 | 5/24/2001 ABD |
| Street: 263 Farmington Ave | City: Farmington | State: CT | | |
| Facility: | Degree: | | / / | / / |
| Street: | City: | State: | | |

Date of medical school graduation: 5 / 24 / 2001 ABD

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 in chronological order from medical school to the present. Include 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.

| | | | From | To |
|---|---|---|---|---|
| Facility: University of Colorado | Position: PGY 1-4 | | 6/23/01 | 6/30/05 |
| Street: 4200 East Ninth Avenue | City: Denver | State: CO | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |
| Facility: | Position: | | / / | / / |
| Street: | City: | State: | | |

PRINT NAME: ANNE BRECKENRIDGE DIXON 

**Hospital Affiliations and Employment**

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

| | | From | To |
|---|---|---|---|
| Facility: Colorado Permanente Medical Group | Position: Physician | 8/1/05 | present |
| Street: 10350 E. Dakota Ave | City: Denver | State: CO | |
| Facility: Exempla St. Joseph's Hospital | Position: Staff Physician | 8/1/05 | present |
| Street: 1835 Franklin St | City: Denver | State: CO | |
| Facility: Exempla Good Samaritan Med. Ctr | Position: Staff Physician | 8/1/05 | present |
| Street: 200 Exempla Circle | City: Lafayette | State: CO | |
| Facility: | Position: | / / | / / |
| Street: | City: | State: | |

1. List other states (abbreviations) where you are currently or have ever been licensed: N/A
2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☑ No
3. List Board Certification(s): ______ Certification date: / /

   ______ Certification date: / /
4. Have you attached an up-to-date copy of your curriculum vitae? ☑ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: Relocating to practice in Medford, Mass
6. Name of Facility: Harvard Vanguard Medical Associates
7. Address: 26 City Hall Mall, ~~Medf~~ City: Medford
8. Anticipated starting date in Massachusetts: 2/20/2006

**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]
Signature of Applicant

12/6/2005
Date

Rev: 10/21/2002

# SUPPLEMENT FORM

PRINT NAME: Anne Breckenridge Dixon DATE: 12/6/05

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

**QUESTIONS** **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, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body 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 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)?

Applicant's Signature: Anne Dixon Date: 12/6/05

| | | 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 Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or 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:** **Date:** 12/6/05

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**Full License Application**

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

# MEDICAL EDUCATION VERIFICATION

**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.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Anne Dixon Date of Birth ____

Print or Type Name: DIXON (Last name) ANNE (First Name) B (Middle Initial) Social Security No: ____

Other Name(s) ____ (Please type or print name(s))

Name of Medical School: University of Connecticut School of Medicine

Address: 263 Farmington Ave City: Farmington State or Province: CT

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

**Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it 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: ____

Undergraduate School Address: ____

(Continued on page 2)

**Full License Application**

**Enrollment and Participation:** Our records indicate that Dixon Anne B.

(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

| **ATTENDANCE DATES:** | **FROM** | **TO** | **FROM** | **TO** |
|---|---|---|---|---|
| | 8/15/97 | 6/8/98 | 7/1/00 | 5/24/01 |
| | 8/17/98 | 5/26/99 | / / | / / |
| | 7/1/99 | 6/30/00 | / / | / / |

**The applicant attended** 164 **total weeks** *or* 44 **total months (must be included)** **of not less than 32 weeks in each academic year of continuing on-campus education.**

***check one*** ☑ was awarded a degree in Doctor of Medicine on (month/day/year) 5/24/01

☐ 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 SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.**

Signature: Linda Greene

Print Name: Linda Greene

Title: Asst Registrar

Date: 12/15/05 Telephone: (860) 679-3125

**This form will not be accepted unless it is stamped with the institutional seal or notarized.**

Seal Verified

DATE: 12/05

INITIALS: CH

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

# POSTGRADUATE TRAINING VERIFICATION

**APPLICANT'S AUTHORIZATION**: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: [signature] Date: 11/10/05

Print or Type Name: Anne B. Dixon

Name of Institution: University of Colorado HSC

**INSTRUCTIONS TO THE PROGRAM DIRECTOR**

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of Colorado Health Sciences Center

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

**Enrollment and Participation:** Our records indicate that Anne Dixon (Print applicant's name) participated in the following program:

| Program Type (internship, residency, fellowship) | PGY (1,2,3,4) | Department or type of specialty training | Dates Attended (MONTH/DAY/YEAR) FROM | TO | Completed (YES/NO) | Accredited By (ACGME, RSC, AOA or not accredited) |
|---|---|---|---|---|---|---|
| Residency | 1-4 | OB-GYN | 6/23/01 | 6/30/05 | YES | ACGME |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

(Continued on page 2)

**POSTGRADUATE VERIFICATION FORM PAGE - 2**

**APPLICANT'S NAME:** ANNE DIXON

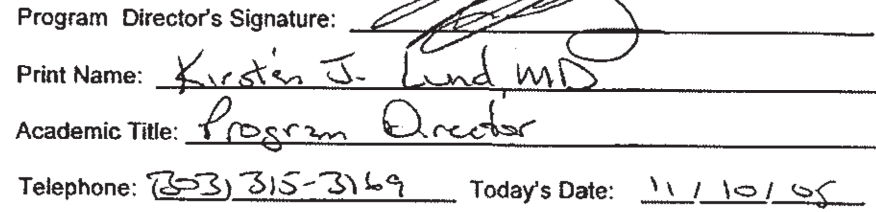
**Unusual Circumstances:** The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

| 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.



**AFFIX INSTITUTIONAL SEAL HERE**

**(If the institution does not have a seal, this form must be notarized by a notary public).**

Program Director's Signature: [signature]

Print Name: Kirsten J. Lund MD

Academic Title: Program Director

Telephone: (303) 315-3169 Today's Date: 11/10/05

**PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.**

Seal Verified

DATE: 12/05

INIT: CH

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

## 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. If you have been in a training program within the past ten (10) years, a copy of this form must be forwarded to your training program risk management office. You must account for any gaps in your claims history. If you have additional liability carriers, you may photocopy this form. **Please return the Malpractice History 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
5. dates of policy coverage must be included.

**Liability Carrier's Instructions: If the applicant has any open or closed cases that have gone to trial, whether or not monies were paid, a copy of the complaint or summons, disposition or judgment and amount of monies paid on behalf of the applicant must be forwarded directly to the Board. IF THE APPLICANT DOES NOT HAVE ANY CLAIMS HISTORY, PLEASE CONFIRM THAT THERE ARE "NO CLAIMS" ON YOUR LETTERHEAD WITH THE DATES OF COVERAGE AND FORWARD TO THE BOARD. TRAINING PROGRAMS ARE ALSO REQUIRED TO PROVIDE THE MALPRACTICE HISTORY AND DATES OF COVERAGE.**

✓ Liability Carrier: (1) University of Colorado Self Insurance & Risk Management Trust Coverage From: 6/23/01 To: 6/23/05
City: Denver State: CO Policy Number: N/A See attached letter

✓ Liability Carrier: (2) Kaiser Foundation Health Plan of Colorado From: 8/05 To: Present
City: Denver State: CO Policy Number: N/A

Liability Carrier: ____ From: __/__ To: __/__
City: ____ State: ____ Policy Number: ____

Applicant's signature: [signature] 11/30/05
Date

Print Name: Anne Dixon

Address: ____ City: ____

State: ____ Zip code: ____

**Additional forms available at the Board's website at www.massmedboard.org**

# Massachusetts Physician Renewal Application

**Physician Name:** Anne B Dixon **License No.:** 227077

## PART A

1) **Current Status:** Active **Renewal Due Date:** 08/19/2006 **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.**

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**Please make corrections** (print)

**2a) MAILING ADDRESS**

☑ *Check here to change this address*

Mailing Address: 26 City Hall Mall
City/Town: Medford State: MA
Zip: 02155 Country: USA

**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**

Phone:

☑ *Check here to change this address*

Business Address: 26 City Hall Mall
City/Town: Medford State: MA
Zip: 02155 Country: USA
Business Telephone: (781) 306 5304

*Business address cannot be a Post Office Box*

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

4) **Fax Number:** ____

| 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? |
|---|---|---|---|---|
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |
| | | | ☐ | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name: Anne B Dixon** **License No.: 227077**

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

**9) What is your principal work setting?** *(See Renewal Instructions, page 4.)*
Principal Work Setting: Change to: Partnership/Group
Please enter the *approximate* number of work hours at your principal work setting: 24

**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 |
|---|---|---|---|---|
| Beth Israel Deaconess Medical Center | ☐ | ✓ | | 24 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

**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: CRICO Change to: ____
Policy dates: From 3/20/06 To 12/31/06
*(required)*

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

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

Check one:
☐ Not involved with direct or indirect patient care in Massachusetts
☐ Government Employee Federal Tort Claims Act (FTCA)
☐ Otherwise exempt *(Please explain):* ____

# Massachusetts Physician Renewal Application

**Physician Name: Anne B Dixon** **License No.: 227077**

**13) Do you perform any surgery in your office?** *(See Renewal Instructions, page 5.)*
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.

| Question | 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

**Physician Name: Anne B Dixon** **License No.: 227077**

## PHYSICIAN PROFILE

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

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

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

## CERTIFICATIONS

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Date: 8 / 14 / 06

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

# Massachusetts Physician Renewal Application

**Physician Name: Anne B Dixon** **License No.: 227077**

## 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: 1205881794
- ☐ 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.
- ☐ 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 13 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: | 207V00000X | Obstetrics & Gynecology |
| Provider Taxonomy: | | |
| Provider Taxonomy: | | |

## NPI REQUIRED INFORMATION

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

Social Security Number: ☐☐☐-☐☐-☐☐☐☐

State of Birth (if US): ____________ Country of Birth (if outside the US): ____________

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: [signature] Date: 8/14/06

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

Back | Home | How to Read a Profile

# Massachusetts Board of Registration in Medicine Physician Profile

## ANNE B DIXON MD

## I. Physician Information

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

| | |
|---|---|
| **License Status:** | Active |
| **License Issue Date:** | 02/01/2006 |
| **Accepting New Patients:** | ~~No~~ Yes |
| **Accepts Medicaid:** | ~~No~~ Yes |
| **Primary Work Setting:** | None Reported Office |
| **Business Address:** | None Reported 26 City Hall Mall Medford MA 02155 |
| **Phone:** | None Reported 781 306 5304 |
| **Translation Services Available:** | None Reported Yes |
| **Insurance Plans Accepted:** | None Reported Please call for list |
| **Hospital Affiliations:** | None Reported Beth Israel Deaconess Medical Center |

## II. Education & Training

| | |
|---|---|
| **Medical School:** | University of Connecticut School of Medicine |
| **Graduation Date:** | 2001 |
| **Post Graduate Training:** | None Reported University of Colorado Health Sciences Center |

## III. Specialty

| | |
|---|---|
| **Area of Specialty:** | Obstetrics and Gynecology |
| **ABMS Board Certification:** | Not Board Certified |

## IV. Honors and Awards

This physician has reported no awards.

## V. Professional Publications

This physician has reported no publications.

## VI. Malpractice Information

Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Board believes that consumers should have access to malpractice information. In these profiles, the Board has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Board has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history. When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- This report reflects data for the last 10 years of a doctor's practice. For doctors practicing less than 10 years, the data covers their total years of practice. You should take into account how long the doctor has been in practice when considering malpractice averages.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the physician. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Board can refer you to other articles on this subject.

**Dr. DIXON has not made a payment on a malpractice claim in Massachusetts in the last ten years.**

## VII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:
The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

**Dr. DIXON has had no criminal convictions in the past ten years.**

B. Hospital Discipline:
This section contains several categories of disciplinary actions taken by Massachusetts hospitals during the past ten years which are specifically required by law to be released in the physician's profile.

**Dr. DIXON has no record of hospital discipline in the past ten years.**

C. Board Discipline:
This section includes final disciplinary actions taken by the Massachusetts Board of Registration in Medicine during the past ten years.

**Dr. DIXON has not been disciplined by the Board in the past ten years.**

---

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 617-654-9830
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Boston MA 02118
Phone 617-654-9800
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

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# Massachusetts Physician Renewal Application

**Physician Name:** Anne B Dixon, M.D. **License No.:** 227077

Cme

## PART A

1) **Current Status:** Active **Renewal Due Date:** 08/19/2008 **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**

RECEIVED
AUG 07 2008
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**
26 City Hall Mall
Medford, MA 02155

Phone: (781)306-5304

☐ *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:**

**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: Board Name | ABMS or AOA | Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required. Certificate/Subspecialty | Delete? |
|---|---|---|---|
| American Board of | | | ☐ |
| Obstetrics + Gynecology | | | ☐ |
| | (ABMS) | | ☐ |
| | | | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name: Anne B Dixon, M.D.** **License No.: 227077**

*(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**

CO → now expired

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

CO

**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? |
|---|---|---|---|
| Beth Israel Deaconess Medical Center | | | ☐ |
| Harvard Vanguard Medical Associates (HVMA) | Medford | MA | ☐ |
| HVMA (private office) | Somerville | MA | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | |
| | | | |

**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: CRICO Change to: ____

Policy dates: From 3/20/2006 To 12/31/2008

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

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

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

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

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

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

☐ Otherwise exempt *(Please explain)*: ____

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

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

# Massachusetts Physician Renewal Application

**Physician Name: Anne B Dixon, M.D.** **License No.: 227077**

**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**<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: Anne B Dixon, M.D.** **License No.: 227077**

## 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: Anne Dixon Date: 7/21/08

**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:** Anne B Dixon, M.D. **License No.:** 227077

**Current Status:** Active **License Expiration Date:** 9/16/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:** 1055 Commonwealth Avenue
Boston
Massachusetts - 02215
United States of America
(617) 616-1631

3) **Email Address:**

4) **Fax Number:**

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**
None Reported

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

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 |
|---|---|
| Beth Israel Deaconess Medical Center | |

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

**Physician Name:** Anne B Dixon, M.D. **License No.:** 227077

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| Marsh USA, Inc | 08/25/2008 | 01/01/2011 | 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?

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

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

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

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

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

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

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

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

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

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

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

**Physician Name:** Anne B Dixon, M.D. **License No.:** 227077

**Current Status:** Active **License Expiration Date:** 9/16/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

   **Mailing Address:**

   **Home Address:**

   **Business Address:**

3) **Email Address:**

4) **Fax Number:**

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**
   None Reported

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

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 |
|---|---|
| Beth Israel Deaconess Medical Center | |
| Harvard Vanguard Medical Associates | Wellesley |

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 06/01/2012 | 12/31/2012 | 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?

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

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

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

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

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

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

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

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

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

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:** Anne B Dixon, M.D. **License No.:** 227077

**Current Status:** Active **License Expiration Date:** 9/16/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

**Mailing Address:**

**Home Address:**

**Business Address:**

3) **Email Address:**

4) **Fax Number:**

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**
None Reported

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

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 |
|---|---|
| Beth Israel Deaconess Medical Center | |
| Harvard Vanguard Medical Associates | Wellesley |

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

**Physician Name:** Anne B Dixon, M.D. **License No.:** 227077

**11) Care of patients in Massachusetts**
**Average weekly hours involved in:** **a) inpatient care** 0 hrs/wk
**b) outpatient care** 40 hrs/wk

**12) Medical Liability Insurance Information**

| Insurance Carrier | Policy Start Date | Policy End Date | Policy Type |
|---|---|---|---|
| CRICO | 01/01/2014 | 12/31/2014 | 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?

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

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

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

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

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

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

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

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

**Physician Name:** Anne B Dixon, M.D. **License No.:** 227077

**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?**

# ANNE B. DIXON, M.D.

02/22/06 22

## EMPLOYMENT

**Colorado Permanente Medical Group, Kaiser Permanente**
Wheatridge, Colorado
*General Practice, Obstetrics and Gynecology*, August 2005 – Present

## EDUCATION

**University of Colorado Health Sciences Center**
Denver, Colorado
*Resident Physician, Obstetrics and Gynecology*, June 2001 – June 2005
*Eligible for Board Certification*

**University of Connecticut School of Medicine**
Farmington, Connecticut
*Doctor of Medicine*, June 2001

**Princeton University**
Princeton, New Jersey
*Bachelor of Arts in Politics, Certificate in Economics*, June 1996

**Loomis Chaffee School**
Windsor, Connecticut
*Graduate*, June 1992

## ACADEMIC HONORS AND RESEARCH

*Administrative Chief Resident, Obstetrics and Gynecology*,
University of Colorado Health Sciences Center, July 2004 – Present

*The Effect of Ovariectomy on Cell Proliferation in the Mammary Gland in Early Lactation*
Mentor: Margaret Neville, PHD, University of Colorado Health Sciences Center, January 2004

*Recurrence Rate of Preterm Premature Rupture of Membranes*
Mentor: Adam Borgida, MD, University of Connecticut School of Medicine
Poster presented at SMFM, February 2001

*Separate and Unequal: The Desegregation of Hartford's Public Schools*
Advisor: James Doig, Princeton University, June 1996

## OTHER INTERESTS AND ACTIVITIES

Junior Fellow, ACOG
Young Advocates Council, Planned Parenthood of the Rocky Mountains
Former horse wrangler and ranch hand, Cody, Wyoming and Granby, Colorado
Avid snowboarder and women's ice hockey player