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

Physician Registration Renewal Application

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

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

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

REDACTED COPY

1. Current Status: Active Registration No.: 75692 Renewal Date: 04/20/2001

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:
JOHN DIORIO JR

B) Home Address:

RECEIVED MAR - 1 2001 BOARD OF REGISTRATION IN MEDICINE

Home Phone:

Business Phone:

Please make corrections (type or print)

Other Name(s): _____

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

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (401) 467-6270

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: M
c) SS#:

5. a) Name of Medical School:
Albany Medical College of Union University
b) Year Graduated: 1975 c) Degree: M.D.

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

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

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

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

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

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

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: 998/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): Hospitals - Women + Infants - RI (AP) 99%
RI Hosp/Miriam Hosp - Prov RI (AP) 1%.

PRINT YOUR LAST NAME: DiOrio LICENSE NUMBER: - 75692 -

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: ProMutual Group # 2-11047 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) 1 5

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

1) Average weekly hours involved in: a) outpatient care 0 hrs/wk b) inpatient care 0 hrs/wk

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

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: John DiOrio Jr MD Date: 2/10/2001

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

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

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

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

Physician Registration Renewal Application

Before proceeding, please read the instruction booklet.
• Copy this form and all attachments for your own records; you will need copies for credentialing and other purposes.

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

Registration No.: 75692 Renewal Date: 04/20/1999 1. Current Status: Active

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

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

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

3. A) Mailing/Home Address:

JOHN DIORIO JR , M.D.

B) Business Address:
1725 BROAD STREET
CRANSTON, RI 02905-2728

Home Phone:
Business Phone: (401)467-6270

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

5. A) Name of Medical School:
Albany Medical College of Union University
B) Year Graduated: 1975 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	1	Obstetrics and Gynecology

Please make corrections (type or print)

Other Name(s): _____

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

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

Home: (____) _____
Business: (____) _____

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

Full Name of Medical School:
_____
_____

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

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

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

Code: _____ Code: _____

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

Federal (DEA): _____
Mass: _____

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

Abbr: ___ ___ ___ ___
Abbr: ___ ___ ___ ___

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

PRINT NAME AND NUMBER: Last Name: Diorio Registration Number: 75692

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

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

If 999, print name(s): Women + Infants Hosp. Providence RI 99%

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

Name of Insurer: The Medical Protective - Indiana 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) 1 5

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

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

2) What is the approximate percentage of your patient care hours in primary care? 35 %

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

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

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

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

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

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

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

Signature: John D. Diorio, MD. Date: 2/03/99

YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION

I. PHYSICIAN INFORMATION

JOHN | | DIORIO | JR
First Name | *Middle Initial* | *Last Name* | *Suffix*

Make changes to name here

Mass License # 75692
License Status Active

First Issue Date 04/08/92

Hospital Affiliation

1725 Broad St.
Cranston, RI 02905-2728
U.S.A.
(401) 467-6270

Make address corrections here:

Make any corrections to above here:
Rhode Island Hospital
Miriam Hospital
Women + Infants Hospital } Prov RI

Insurance Plan Affiliation:
All Major carriers including Blues - UHP - Pilgrim & Aetna - Hancock - Travelers etc

Licenses Held in Other States:
RI

(Please correct as necessary)

Accepting New Patients? ☒ Yes ☐ No
Accept Medicaid? ☒ Yes ☐ No

II. EDUCATION & TRAINING

Albany Medical College of Union University | MD | 75
Medical School | *Degree* | *Date*

Make corrections here

Residency Program(s) | *Start* | *End*
Rhode Island Hosp / Women + Infants Prov. RI | 7/1/75 → | 6/30/79

Residency Program(s) | *Start* | *End*

Residency Program(s) | *Start* | *End*

III. SPECIALTY

Primary Specialty: Obstetrics and Gynecology

Secondary Specialty:

Make any corrections here:

BOARD CERTIFICATION

Certifying Board Name: Board of Obstetrics and Gynecology

Certifying Board Name:

Make any corrections here:
American Board of Obstetrics + gynecology

IV. BOARD DISCIPLINE

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

Nature	Date	Board Action
None		

V. HOSPITAL DISCIPLINE

Hospital	Date	Disciplinary Action
None		

VI. CRIMINAL CONVICTIONS

The Board of Registration is unable to obtain accurate data for this category at the present time. This information will be included when the court system is fully computerized. Please list any criminal convictions. Include conviction date and nature of complaint None

VII. MALPRACTICE

Details of claims paid for Dr. DIORIO in past 5 years— as stated in instructions. No. of Years in Practice: # 17 years.

Date 6/28/91	Amount Paid 0.0000 $200,000.00	Basis for Complaint	Premature delivery @ home in
Date	Amount Paid	Basis for Complaint	1979. Pt under my partner's
Date	Amount Paid	Basis for Complaint	care. I settled as part
Date	Amount Paid	Basis for Complaint	of group. I cared for patient
Date	Amount Paid	Basis for Complaint	in subsequent delivery
Date	Amount Paid	Basis for Complaint	

VIII. PHYSICIAN HONORS & PEER-REVIEWED PUBLICATIONS

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

Awards, Honors	Publications
Women & Infants Hospital OB-GYN Resident Teaching Award in Surgery 1982, 1984, 1985 and 1988	See Back →
grad. ALBANY MED cum laude, Pharmacology Award	
AED - Natl Premed Honor Society	
AOA - Natl Medical Honor Society	
Clinical Assistant Prof. Brown Medical School.	

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

DiOrio, J. and Lowe, L.: Hemangioma of the Ovary in Pregnancy - A Case Report, Journal of Reproductive Medicine 24:232, 1980

DiOrio, J.: Adult Respiratory Distress Syndrome Occuring After Therapy with Diazoxide Betamethasone for Premature Labor - A Case Report, R.I. Medical Journal 65:275, 1982

DiOrio, J.: Short-Course Antibiotic Prophylaxis in First Trimester Abortion, R.I. Medical Journal 67:499, 1984

Bellucci, M. and DiOrio, J. and Moubayed, S.: Uterine Inversion Secondary to Placenta Accreta in a DES Exposed Parturient, Journal of Reproductive Medicine 32:236, 1987

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

Physician Registration Renewal Application

MK 3-11

Before proceeding, please read the instruction booklet.

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

RECEIVED MAR 1 1997

Registration No.: 75692 Renewal Date: 04/20/97

1. Activity Status: (Check only one) ☒ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

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

3. A) Mailing/Home Address:

JOHN DIORTO JR . M.D.

B) Business Address:
1725 BROAD ST
CRANSTON, RI 02905-2728

Home Phone:
Business Phone: (401)467-6270

4. A) Date of Birth: C) Sex: M
B) Lic. Issue Date: 04/08/92 D) SS#:

5. A) Name of Medical School:

Albany Medical College of Union University
B) Year Graduated: 75 C) Degree: MD

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

Code(s)	Hours per Week in Mass.	
OBG	1	Obstetrics and Gynecology

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

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

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

Corrections (type or print)

Other Name(s):

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

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

Home: ( )
Business: ( )

Date of Birth (M/D/Y): / / Sex (M/F):
Lic. Issue Date (M/D/Y): / / SS#:

Full Name of Medical School:

Year Graduated: Degree (MD/DO):

Code(s)	Hours Per Week in Mass.
	<1hr/week

If OS, Print Specialty:

Code: Code:

Federal (DEA):
Mass:

Abbr:

Abbr:

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

LLS

PRINT NAME AND NUMBER: Last Name: Diorio, John Registration Number: 75692

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

Facility Code: 998 /✓(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
Facility Code:____/__(AP) Facility Code:____/__(AP) Facility Code:____/__(AP)
If 999, print name(s): 998 facilities ; Women + Infants RI ; Miriam, RI Hospital Providence RI

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

Facility Code:____ Facility Code:____ Facility Code:____ Facility Code:____ Facility Code:____
If 999, write Name(s):____

11. My medical malpractice insurance is covered by a) ✓ Insurance Carrier ____b) Letter of Credit
Name of Insurer: Medical Protective Company Fort Wayne Indiana policy # 606738

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a)____ Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption:____

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

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

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

1) Average weekly hours involved in: a) outpatient care '0' hrs/wk b) inpatient care '0' hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 50 %

PART A

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

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ Waiver requested (waiver form due 30 days prior to date of license expiration). ☐ Training Program exemption		

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

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

Signature John Diorio MD. Date: 2/21/97

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

Registration No.	Status	Fee	Renewal Date	Late Fee
75692	ACTIVE	$250.00	04/20/95	$25.00

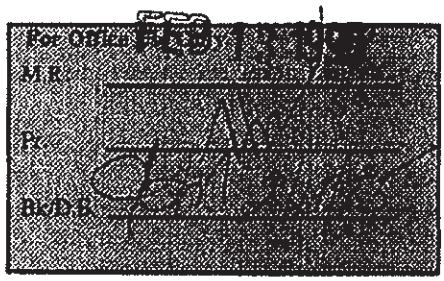
Mailing Address:
JOHN DIORIO JR , M.D.

Correction of Mailing Address

Address (Mailing): _____
_____
City/Town: _____
State: _____
Country: _____

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

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



Pre-Printed Information

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

2. Business Address:
1725 BROAD STREET
CRANSTON, RI 02905

3. Date of Birth: Sex: M
Lic. Issue Date: 04/08/92 SS#:

Home Phone Business Phone
(401)467-6270

4. Name of Medical School:
Albany Medical College of Union University
Year Graduated: 75 Degree: MD

5. a) Other states where you are now licensed to practice (Abbr): RI CT
b) States where you previously were licensed to practice (Abbr): RI CT

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

Code	Hours per Week in Mass.
OBG	1

Obstetrics and Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
Code: OG Code:

8. Drug license number(s), if any:
a) Federal (DEA)
b) Massachusetts

Corrections of Pre-Printed Information

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

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____
Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____
_____
Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
_____	Zero
_____	_____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

9. Activity Status: I am applying to be registered with the following status: (ACTIVE) X INACTIVE ____

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

PRINT NAME AND NUMBER: Physician Last Name: Diorio Registration Number: 75692

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

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

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

If 999, print name(s): Women + Infants Hospital, Miriam Hospital, Rhode Island Hospital (all Providence RI)

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

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

If 999, write name(s): ___

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit ___ If applicable, check one.
List Insurer: The Medical Protective Company of Fort Wayne Indiana

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

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

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

b) Care of patients in Massachusetts (See instruction booklet.)
i) How many hours per typical week are you currently involved in *outpatient* care in Mass? 0 hrs/wk
ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? 0 hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 75 %

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

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

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

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

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

Signature: John Diorio MD Date: 2/8/95

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

Registration No.	Status	Fee	Renewal Date	Late Fee
75692	ACTIVE	$250.00	04/20/93	$25.00

Mailing Address:
JOHN DIORIO JR , M.D.

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

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

For Office Use Only
M.R. FEB 11 1993
Pr. ~~FEB 11 1993~~
Bk/D P 2/12/93 EN

Pre-Printed Information

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

2. a) Address (Home):

b) Address (Business):
1725 Broad Street
, Cranston R.I. 02905

Corrections of Pre-Printed Information
Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): 1725 Broad ST.
City/Town: Cranston R.I. 02905
Country Code: 0 If 999 print Country: _____

3. Date of Birth: Sex: M
Lic. Issue Date: 04/08/92 SS#:
Telephone Number:
Home Business
(401)467-6270

Date of Birth (M/D/Y): / / Sex (M/F): _____
Lic. Issue Date (M/D/Y): / / SS#: _____
Telephone Number:
Home: ( ) Business: ( )

4. Name of Medical School:
Albany Medical College of Union University
Year Graduated: 75 Degree: MD

Full Name of Medical School: _____
Year Graduated: _____ Degree (MD/DO): _____

5. a) Other states where you are now licensed to practice (Abbr): RI, CONN.
b) States where you previously were licensed to practice (Abbr): RI, CONN.

CONN. _____ _____ _____ _____
CONN. _____ _____ _____ _____

6. Specialty Code(s) (See Table 2):

Code	Hours per Week in Mass.
0	
0	

Code	Hours per Week in Mass.
0 B G	41

If OS, print specialty: _____

7. a) If you are currently American Specialty Board Certified, enter Codes: (See Table 3)
Code: OG Code:

b) If you previously were American Specialty Board certified, but are no longer, please enter codes of prior certification: (See Table 3)
Code: Code:

OG
Code: _____ Code: _____

Code: _____ Code: _____

8. Drug License Number(s), if any: a) Federal (DEA)
b) State (MA)

Federal (DEA): _____
State (MA): _____

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

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: Diorio Registration Number: 75692

10. **Activity Status:** I am applying to be registered with the following status: Active X Inactive ___

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT___ If applicable, check one.

List Insurer: Rhode Island MM JUA

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am

(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:___ (ii) OTHERWISE EXEMPT: ___

(State how otherwise exempt): ___

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

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

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

If 999, print name(s): Women + Infants Hosp, Miriam Hospital, Rhode Island Hosp (Prov. RI)

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: 0 4 4 Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): ___

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

14. a) What is your principal work setting? (See Table 5) 1 5

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

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

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 41 hrs/wk in MA

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

IN THE PAST TWO YEARS:

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

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

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

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

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

Signature: John Diorio MD. Date: 2/6/93

03/03/97

Massachusetts Board of Registration
Physician Profile

JOHN DIORIO JR, MD

This Profile is not available for public release until 21

I. Physician Information

The information in sections I - V has been provided

Dr. DIORIO has been fully licensed in Massachusett

Accepting new patients? Yes Accepts

Primary work setting: Private Office

Business address: 1725 BROAD ST
CRANSTON, RI 02905-2728
Phone: 401-467-6270

Translation services available: ~~None~~ Spanish.

Insurance Plans Accepted	Hospital
BCBS (Indemnity)	Out of S
Aetna	
John Hancock (State)	
UNITED HEALTHCARE	
HARVARD PILGRIM HEALTHCARE	
OTHER PLANS - Health Mate Blue Chip U.S. Health Care	

II. Education & Training

Medical School: Albany Medical College of Uni
Graduation Date: 1975

Post Graduate Training:
07/01/75 - 06/30/79 RHODE ISLAND HOSPITAL / Women + Infants Hospital - Brown Medical School Residency

III. Specialty

Obstetrics and Gynecology
ABMS Board Certified: Board of Obstetrics and Gynecology

IV. Honors and Awards

WOMEN & INFANTS HOSPITAL OB-GYN RESIDENT TEACHING AWARD IN SURGERY 1982,1984,1988,1996.
GRAD ALBANY MED CUM LAUDE,PHARMACOLOGY AWARD.
AED-NAT'L PREMED HONOR SOCIETY.
AOA-NAT'L MEDICAN HONOR SOCIETY.
CLINICAL ASSISTANT PROF BROWN MEDICAL SCHOOL.

V. Professional Publications

UTERINE INVERSION SECONDARY TO PLACENTA ACCRETA IN A DES EXPOSED PARTURIENT,J OF REPRODUCTIVE MEDICINE,1987.
SHORT-COURSE ANTIBIOTIC PROPHYLAXIS IN FIRST TRIMESTER ABORTION,RI MED JOURNAL,1984.
ADULT RESPIRATORY DISTRESS SYNDROME OCCURING AFTER THERAPY WITH DIAZOXIDE BETAMETHASONE FOR PREMATURE LABOR-A CASE REPORT,RI MED JOURNAL,1982.
HEMANGIOMA OF OVARY IN PREGNANCY-A CASE REPORT, J OF REPRODUCTIVE MEDICINE,1980.

03503 O.K (1)

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

RECEIVED
NOV 25 1991
BOARD OF REG IN MEDICINE
COMMONWEALTH OF MASS.

Fee to be submitted

Filed: 11/26/91 For Office Use Application #

By:

Form of Fee: Certificate # 75692 Date of Issue 4/8/92

Please Print

SWORN STATEMENT

Date: 11/19/91

Name John (First) Diorio Jr. (Middle / Last) Address*

Date of Birth

Place of Birth Providence R.I. Address valid from: (Dates) Aug. - 1980

Name on Birth Certificate John DiOrio Jr Phone # DAY: 401 447-6270 HOME:

Pre-Medical Education

School Providence College R.I.

Years Attended 1967 → 1971

Medical Education

School ALBANY Medical College N.Y.

Years Attended 1971 - 1975 NY003

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates
Rhode Island Hospital	Medical Intern	7/1/75 → 6/30/76
Women & Infants (Prov. RI)	OBGYN Resident	7/1/76 → 6/30/79

Is this your first license? No If applicable, please list all other states where you are or have been licensed:
Rhode Island

Other names under which you have been licensed: none

List Specialty Boards by which you are certified: American Board of OBGYN (1981)

REASON APPLYING FOR A MASS. LICENSE: Performance of Consulting activity at Cottage Hosp. Nantucket Mass.

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

AFFADAVIT OF APPLICANT:

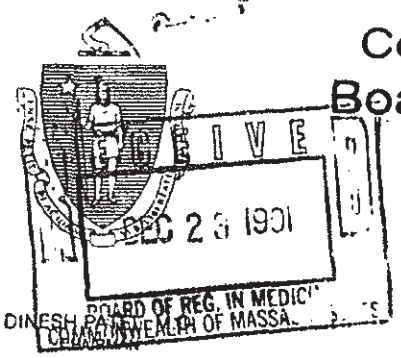
I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

John DiOrio Jr Date: 11/19/91

(SIGNATURE OF APPLICANT)

Batch # 343 By FP

FED. OK Date 12/10/91



DINESH PATEL, M.D.
CHAIRMAN

Commonwealth of Massachusetts
Board of Registration in Medicine

FORM E

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it **DIRECTLY TO THE ADDRESS ABOVE.** This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT John Diorio Jr. M.D. CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

Providence College, Providence, Rhode Island
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: ALBANY MEDICAL COLLEGE
NAME OF MEDICAL SCHOOL

Albany New York USA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT John DiOrio, Jr.
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR 4 ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: ALBANY MEDICAL COLLEGE
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

FORM E, CONT'D.

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

NAME OF APPLICANT: John Diorio Jr M.D.

TO MEDICAL SCHOOL: (Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.)

FROM:	09/08/71			TO:	06/02/72			
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	09/07/72			TO:	06/01/73			
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	09/04/73			TO:	09/02/74			
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	09/03/74			TO:	05/17/75			
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:				TO:				
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:				TO:				
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	

AND HAS RECEIVED/WILL RECEIVE A DEGREE OF Doctor of Medicine

ON May 22 19 75.

X [signature]

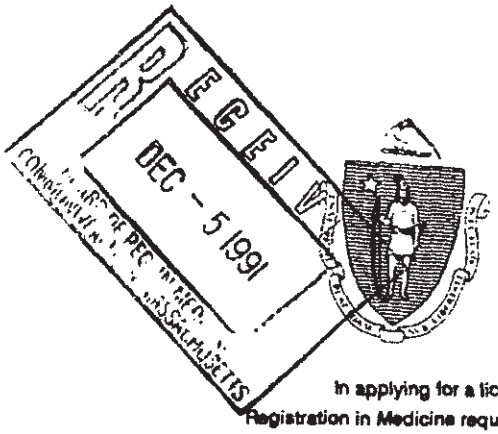
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Richard H. Edmonds, Ph.D., Executive Associate Dean

NAME AND TITLE (Please type or print)

SCHOOL SEAL

DATE: 12/17/91



RECEIVED
NOV 22 1991
BOARD OF MEDICAL LICENSURE & DISCIPLINE

RETURN TO: BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR
BOSTON, MASSACHUSETTS 02111

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please send this form directly to the Board at the above address. Your early response is greatly appreciated.

SIGNATURE OF PHYSICIAN*: John Diorio Jr M.D.

NAME OF PHYSICIAN: John Diorio Jr LICENSE NUMBER: 5123 (RI)

The State Board fills out the following information:

State of: Rhode Island Full Name of Licensee: John Diorio, M.D.

Graduate of: Albany Med School 5-22-75

License Number: 5123 Issue Date: 29-77

By Endorsement/Reciprocity with: NAT BD By Your State Board's Written Examination? ___Yes ___No

Is License current? X Yes ___No

If No, why not? n/A

Has this License been suspended or revoked? ___Yes X No

If yes, why? n/A

Has licensee ever been on probation? ___Yes X No

If yes, why? n/A

Has licensee ever been requested to appear before your Board? ___Yes X No

If yes, why? n/A

Derogatory information, if any? n/A

Comments, if any? n/A

Signed [signature]

Title: Dep. Chief Adm. Officer

BOARD SEAL

State Board: Med. Board Date: 11-29-91

*NOTE TO APPLICANT: Most states charge a fee for this service. We suggest that you call the different states in which you are licensed before you mail this form.

CURRICULUM VITAE: JOHN DiORIO JR., M.D.

DATE OF BIRTH:	
PLACE OF BIRTH:	Providence, Rhode Island
SOCIAL/FAMILY STATUS:	Married Wife - Children -
HOME ADDRESS:	
SPECIALTY:	Obstetrics & Gynecology
BOARD CERTIFICATION:	Obstretics & Gynecology Date: 1981
EDUCATION:	High School - LaSalle Academy, Providence, RI 1967 College - Providence College, Providence, RI 1971 B.S. *in Biology Magna Cum Laude* Medical School - Albany Medical College of Albany, NY M.D. Cum Laude 1975
POSTGRADUATE MEDICAL TRAINING:	Intern in Medicine; Rhode Island Hospital 7/75 - 6/76 Resident in Obstretics & Gynecology; Rhode Island Hospital & Women & Infants Hospital of RI 7/76 - 6/79
CURRENT PROFESSIONAL STATUS:	Solo Practice: Gynecology 1725 Broad Street Cranston, Rhode Island 02905
TEACHING APPOINTMENTS:	Clinical Assistant Professor of Brown University Medical School 1979 to present Senior Clinical Instructor of Tufts University School of Medicine 1979 to present
PROFESSIONAL MEMBERSHIPS:	Alpha Epsilon Delta - National Premedical Honor Society Alpha Omega Alpha - National Medical Honor Society Fellow - American College of Obstretics & Gynecology Providence Medical Society Rhode Island Medical Society American Medical Association American Fertility Society
PROFESSIONAL LICENSURE:	Rhode Island M.D. 5123 Date: 1977

HOSPITAL AFFILIATIONS:

Women & Infants Hospital, Providence, RI

Miriam Hospital, Providence, RI

Rhode Island Hospital, Providence, RI

PROFESSIONAL PUBLICATIONS:

DiOrio, J. and Lowe, L.: Hemangioma of the Ovary in Pregnancy - A Case Report, Journal of Reproductive Medicine 24:232, 1980

DiOrio, J.: Adult Respiratory Distress Syndrome Occuring After Therapy with Diazoxide Betamethasone for Premature Labor - A Case Report, R.I. Medical Journal 65:275, 1982

DiOrio, J.: Short-Course Antibiotic Prophylaxis in First Trimester Abortion, R.I. Medical Journal 67:499, 1984

Bellucci, M. and DiOrio, J. and Moubayed, S.: Uterine Inversion Secondary to Placenta Accreta in a DES Exposed Parturient, Journal of Reproductive Medicine 32:236, 1987

AWARDS:

Teaching

Women & Infants Hospital: OB/GYN Residents Teaching Award in Surgery 1982 - 1984 - 1985 - 1988

BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC. NUMBER, OPTIONAL

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☐
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD	1	42422	$100	100	03	28	87	

NOTE! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.

PAYABLE TO:
COMMONWEALTH OF
MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

JOHN D DIORIO

RECEIVED FEB 1987

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: John D. Diorio
2. Date of Birth: ___ (MONTH) ___ (DAY) ___ (YEAR)
3. Medical School: NYU M.D.? [X] D.O.? [ ] (Check One.)
4. Country where Medical School located: USA
5. Date of Graduation: 6/76
6. American Specialty Board Certified? [X] (Check if yes.)
   Which Boards? Internal Medicine
7. Principal Specialty(ies): ___
8. Principal work setting: Private/Family Practice
9. Home address: ___
10. Principal business address: 624 Main Street
    Brockton, MA 02401
11. List all hospitals at which you have currently effective privileges: Brockton City Hospital, Cardinal Cushing Hospital
12. List all hospitals at which you have held privileges in the past 20 years: Same as above
13. States other than Massachusetts in which you are presently licensed to practice: n/a
14. List any other states where you were previously licensed to practice: n/a

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)?		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: MORE THAN 100 CME CREDITS IN IMMEDIATE 2 YRS. PREVIOUS TO 3/29/87 CALL AMA CAT. 1)
26. I am an active [X] inactive [ ] practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

John D Diorio MD
SIGNATURE

DATE: 2/4/87

(See Reverse Side)

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

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: John Dionio Jr.   Day time phone #: 401-4676270

MAILING ADDRESS: ______   Business Address: 1725 Broad Street
Cranston RI. 02905

Address valid until: Above is mailing -: valid indefinitely

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

YES NO

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

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

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

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

I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.
I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec 51A.
I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: J. Dionio Jr. MD   DATE: 11/19/91

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.: 75692 Renewal Date: 04/20/2003

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. JOHN DIORIO JR

B) Home Address:

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Home Phone:

Business Phone: 401-467-6270

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: M
c) SS#:

5. a) Name of Medical School:
Albany Medical College of Union University
b) Year Graduated: 1975 c) Degree: M.D.

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

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

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

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

9. a) Other states where you are now licensed to practice (Abbr.)
RI. ___ ___ ___ ___ ___ ___ ___
b) States where you were previously licensed (Abbr.)
CT. ___ ___ ___ ___ ___ ___ ___

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: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ % Facility Code: ___/___ (AP) ___ %
If 999, print name(s): Women & Infants Hosp and R.I. Hospital Prov. RI
99+% ≤1% Time % spent

PRINT YOUR LAST NAME: Diorio MASS.# LICENSE NUMBER: 75692

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): WOMEN + INFANTS Indemnity PLAN. Policy dates: From: 5/16/02 To: 5/16/03
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) 1 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

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

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

	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: John Davis MD Date: 2/27/2003

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

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

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

Massachusetts Physician Renewal Application

Physician Name: JOHN DIORIO JR **License No.:** 75692

PART A

1) Current Status: Active **Renewal Due Date:** 03/23/2005 **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

☐ *Check here to change this address*

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

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2b) HOME ADDRESS

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

1725 BROAD STREET
CRANSTON, RI 02905-2728

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Phone: (401)467-6270

☐ *Check here to change this address*

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401 461 1390

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:

Board Name	**ABMS or AOA**		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**		
			Certificate/Subspecialty	**Correct?**	**Delete?**
American Board of OB&GYN	☒		Obstetrics & Gynecology	☒	☐
	☐	☐		☐	☐
	☐	☐		☐	☐
	☐	☐		☐	☐

Massachusetts Physician Renewal Application

Physician Name: JOHN DIORIO JR **License No.:** 75692

(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:	RI
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	CT

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

Principal Work Setting: Private Office Change to: _____

Please enter principal work setting hours per week here: 45

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 ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	# Hours per Week
Out of State Hospital	☐	Admitting		
Women + Infants Hosp. of R.I	☐	ADMITTING		≤ 5.0
Rhode Island Hospital	☐	CONSULTING		0
MIRIAM Hospital of R.I	☐	CONSULTING		0
Womens Medical Center of RI	☐	ACTIVE		≤ 15.0
Blackstone Valley Surgicare (RI)	☐	ACTIVE		≤ 1.0
	☐			

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: ProMutual Group

Change to: Womens + Infants Hosp. Indemnity Fund. of Women + Infants Hospital Providence RI (See ATTACHED)

Policy dates: From 7/01/2004 To 6/30/2005 *(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: JOHN DIORIO JR **License No.: 75692**

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

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

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

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

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: JOHN DIORIO JR **License No.: 75692**

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: 1 / 25 / 2005

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: JOHN DIORIO JR **License No.:** 75692 Yes

(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:	RI
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	CT

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

Principal Work Setting: Private Office Change to: _____

Please enter principal work setting hours per week here: 45

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 ☐

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	# Hours per Week
Out of State Hospital	☐	Admitting		
Women + Infants Hosp. of R.I	☐	ADMITTING		≤ 5.0
Rhode Island Hospital	☐	Consulting		0
Miriam Hospital of R.I	☐	Consulting		0
Womens Medical Center of RI	☐	Active		≤ 15.0
Blackstone Valley Surgicare (RI)	☐	Active		≤ 1.0
	☐			

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: ProMutual Group Change to: Womens + Infants Hosp. Indemnity fund. of Women + Infants Hospital Providence RI (See ATTACHED)

Policy dates: From 7/01/2004 To 6/30/2005 *(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):* _____

Dr. John Diorio JR

License Number: 75692

Data Date

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 7 9 0 7 6 6 5 1 7

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	2 0 7 V 0 0 0 0 0 X	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): Rhode Island 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: _____ Date: 1/26/2007

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

Dr. John Diorio JR

01/23/2007

Dear Colleague:

As you may know, the Health Insurance Portability and Accountability Act (HIPAA) mandates the use of the National Practitioner Identifier (NPI), a unique identifier for health care providers. The NPI program is overseen by the Centers for Medicare and Medicaid Services (CMS) under the Department of Health and Human Services. Under the final HIPAA NPI rule, all individual and organization covered providers will be required to obtain a NPI by May 23, 2007. Without this number, you may be ineligible for reimbursement from federally-funded benefits programs. As a condition for renewal of your license, you must complete the NPI form on the attached page.

The Massachusetts Board of Registration in Medicine (Board) is assisting physicians to obtain their NPI numbers. In addition to providing this service for physicians, the Board is the designated repository for electronic storage and dissemination of the NPI number. By having your NPI in this central repository, we hope to reduce the amount of administrative duplication in your office.

Please follow the instructions on the NPI form on the back of this letter. If you already have a NPI number, you must enter it in the space provided. If you have not yet submitted an application for a NPI number, you may request that the Board apply for the NPI number on your behalf, or you must indicate that it is being requested by another entity. You must check one of the boxes regarding NPI and you must sign and date the form to authorize the Board to provide the NPI number to authorized entities, although this is not required. Should you need any assistance in completing the NPI form, please contact the NPI coordinator at (617) 654-9810.

I would also like to take this opportunity to thank you for your continued service to the citizens of the Commonwealth.

Sincerely,

Martin C. Crane, M.D.
Board Chair

PLEASE COMPLETE NPI FORM ON THE BACK OF THIS LETTER AND RETURN TO THE BOARD IN THE GREEN ENVELOPE. PLEASE REMEMBER TO SIGN AND DATE THE FORM BEFORE MAILING. THANK YOU

Massachusetts Physician Renewal Application

Physician Name: John Diorio, M.D. **License No.:** 75692

PART A

1) Current Status: Active **Renewal Due Date:** 03/23/2007 **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

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

1725 Broad Street

Cranston, RI 02905-2728

Phone: (401)467-6270

☐ *Check here to change this address*

RECEIVED
MAR 22 2007

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401-461-1390

Correct your E-mail and Fax Number below:

_____

_____

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

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

List Certifying Board(s) below:		**Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.**	
Board Name	**ABMS or AOA**	**Certificate/Subspecialty**	**Delete?**
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	☐
			☐
			☐
			☐

Massachusetts Physician Renewal Application

Physician Name: **John Diorio, M.D.** License No.: 75692

(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:		RI
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		CT

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?
Out of State Hospital			☐
			☐
			☐
			☐
			☐

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

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

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

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

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

☑ **Insurance Carrier** ***(complete below)*** Women's & Infants Hospital

Current Insurance Carrier: ProMutual Group Change to: of RI Indemnity

Policy dates: From 7/01/06 To 6/30/07

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

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

☐ **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: John Diorio, M.D. License No.: 75692

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 a) **NEW:** Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period?** (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: John Diorio, M.D. License No.: 75692

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: John Diorio Date: 3/16/2007

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: John Diorio, M.D. License No.: 75692

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 7 9 0 7 6 6 5 1 7

☐ 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 V 0 0 0 0 0 X	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): R.I. 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: John Diorio J MD Date: 3/16/2007