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

CM 1-11-01

# 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.**

REDACTED COPY

JAN 10 2001
IN MEDICINE

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

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

1. Current Status: Active  Registration No.: 60391  Renewal Date: 03/04/2001

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:
ROBERT R WILLIAMS

B) Home Address:

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: ( ____ ) ____

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:

McGill University Faculty of Medicine

b) Year Graduated: 1968 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.)
~~VT RI~~

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

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): ____

PRINT YOUR LAST NAME: ______________________ LICENSE NUMBER: __________

11. My medical malpractice insurance is covered by a) ☐ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: ______________________ Alternatively, indicate as follows:

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

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption: ______________________

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Signature: Robert R Williams MD Date: 1 / 7 / 01

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

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

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

A.F.D

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Approved:
Disapproved:

Application for Endorsement Registration - NATIONAL BOARDS
(Fee- $150. must accompany APPLICATION - No currency or personal checks)

Filed: 7-6-88
By: Carol
Form of Fee: CK

FOR OFFICE USE

Application # 64697
Certificate # 60391
Date of Issue: 9/28/88

PLEASE TYPE OR PRINT

SWORN STATEMENT

Name Robert Raymond Williams
First Middle Last

Date of Birth

Place of Birth Willits, California

Name on Birth Certificate Robert Raymond Williams

Mailing Address:

Phone #

| Pre-medical Education | Medical Education |
|---|---|
| School University of California-Davis Campus | School McGill University, Montreal, Quebec |
| Dates Attended Sept 1960 → June 1964 | Dates Attended Sept. 1964 → May 1968 |

POSTGRADUATE EDUCATION AND HOSPITAL APPOINTMENTS

| Place | Position | Dates |
|---|---|---|
| Women & Infants Hospital of RI | Residency in OBS-GYN | July 1972 → June 1975 |
| Chelsea Naval Hospital, Chelsea Mass. | Rotating Internship | July 1968 → June 1969 |
| Women & Infants Hospital of RI | Full Staff Privileges in OBS-GYN | July 1975 → June 1979<br>Oct. 1984 → Present |

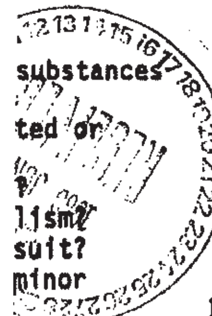
List all other states where you are or have been licensed: California, Oregon, Vermont, Rhode Island

Are you a Diplomate of a Specialty Board? Yes - American Board of Obstetrics & Gynecology
(name, if applicable)

| | | Yes | No |
|---|---|---|---|
| 1. Hav | elled? | 1. | |
| 2. Hav | | 2. | |
| 3. Hav any | before | 3. | |
| 4. Hav | | 4. | |
| 5. Has eve | substances | 5. | |
| 6. Hav bee | ted or | 6. | |
| 7. Hav | | 7. | |
| 8. Hav | lism | 8. | |
| 9. Has | suit? | 9. | |
| 10. Hav tra | minor | 10. | |

If you ... LS:

New Address



## I. PHYSICIAN INFORMATION

| ROBERT | R | WILLIAMS | |
|---|---|---|---|
| *First Name* | *Middle Initial* | *Last Name* | *Suffix* |

*Make changes to name here*

Mass License # 60391 First Issue Date 09/28/88
License Status Active

Harv Comm. Hlth Plan
400 Bald Hill Road
Warwick, RI 02886
U.S.A.
(401) 732-0300

**Hospital Affiliation**

Out of State Hospital
Harvard Pilgrim Health Care

*Make address corrections here:*

*Make any corrections to above here:*

Accepting New HPHC Patients

**Insurance Plan Affiliation:**
CRICO

**Licenses Held in Other States:**
VT
~~OR~~
RI

*(Please correct as necessary)*

Oregon license allowed to expire in 1992. I had not practiced there since 1979 and do not plan to in the future.

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

## II. EDUCATION & TRAINING

| McGill University Faculty of Medicine | MD | 68 |
|---|---|---|
| *Medical School* | *Degree* | *Date* |

*Make corrections here*

Women & Infants Hospital of RI (Brown University Program) — *Residency Program(s)* — *Start* July 72 — *End* June 75

~~Chelsea~~ Chelsea Naval Hospital Internship - Rotating — ~~*Residency Program(s)*~~ — *Start* July 68 — *End* June 69

Chelsea, MA — *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:*
Board Certified 1979
Board Re-Certified 1994

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

# Physician Registration Renewal Application

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

RECEIVED
REGISTRATION
4/1/97

Registration No.: 60391 Renewal Date: 03/04/97

1. Activity Status: (Check only one)
   - [x] 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:

   ROBERT R WILLIAMS, M.D.

   B) Business Address:
   HARV COMM HLTH PLAN
   400 BALD HILL ROAD
   WARWICK, RI 02886

   Home Phone: ( ) -
   Business Phone: (401)732-0300
4. A) Date of Birth: C) Sex: M
   B) Lic. Issue Date: 09/28/88 D) SS#:
5. A) Name of Medical School:
   McGill University Faculty of Medicine
   B) Year Graduated: 68 C) Degree: MD
6. Specialty Code(s) (See Table 1)

| Code(s) | Hours per Week in Mass. | |
|---|---|---|
| OBG | 0 | 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: VT RI
   B) States where you previously were licensed to practice
   Abbr: CA OR

**Corrections (type or print)**

Other Name(s):

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

Other Address: Harvard Pilgrim Health Care of New England
City/Town: 400 Bald Hill Road State:
Zip: Warwick, RI Country: 02886

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.

If OS, Print Specialty:

Code: Code:

also → Federal (DEA):
Mass:

Abbr:

Abbr:

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

**PRINT NAME AND NUMBER:** Last Name: Williams, Robert R. Registration Number: 60391

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): Women & Infants Hospital of RI, Miriam Hospital, Rhode Island Hospital – all in 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: Controlled Risk Ins. Co of Vermont

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) 4 0

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 ? ___%

# 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 Robert R Williams MD Date: 2/2/97

# 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 |
|---|---|---|---|---|
| 60391 | ACTIVE | $250.00 | 03/04/95 | $25.00 |

Mailing Address:
ROBERT R WILLIAMS, 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. Home Address:
3. Date of Birth: Sex: M
   Lic. Issue Date: 09/28/88 SS#:

   Home Phone: ( ) -
   Business Phone: (401)732-0300
4. Name of Medical School:
   McGill University Faculty of Medicine
   Year Graduated: 68 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr): VT OR RI
   b) States where you previously were licensed to practice (Abbr): CA OR
6. Specialty Code(s) (See Table 1):
   Code / Hours per Week in Mass.
   OBG 4 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): ______

VT RI
CA OR

Code: OBG
Hours per Week in Mass.: 0 (zero)
If OS, print specialty: ______

Code: ______ Code: ______

Federal (DEA): ______
Mass: ______

9. Activity Status: I am applying to be registered with the following status: ACTIVE ✓ INACTIVE ___

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

Note: #5 - This does Not represent any change in the past 2 years.

PRINT NAME AND NUMBER: Physician Last Name: WILLIAMS Registration Number: 60391

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

Facility Code: 998 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): ___

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

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

If 999, write name(s): ___

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

List Insurer: CRICO

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

State how otherwise exempt: ___

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

13. a) What is your principal work setting? (See Table 4) 40 (40)

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 ✓ 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: Robert R Williams MD Date: 1/19/95

# 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 |
|---|---|---|---|---|
| 60391 | ACTIVE | $250.00 | 03/04/93 | $25.00 |

**Mailing Address:**
ROBERT R WILLIAMS, 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. MAR 01 1993 FP
Pr.
Bk/D.E. 3/2/93 EN

**Pre-Printed Information**

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

   b) Address (Business):
   RHODE ISLAND GROUP
   400 BALD HILL ROAD
   WARWICK, RI 02886
3. Date of Birth: Sex: M
   Lic. Issue Date: 09/28/83 SS#:
   Telephone Number:
   Home
   Business
   (401)732-0300
4. Name of Medical School:
   McGill University Faculty of Medicine
   Year Graduated: 68 Degree: MD
5. a) Other states where you are now licensed to practice (Abbr): VT OR RI
   b) States where you previously were licensed to practice (Abbr): CA
6. Specialty Code(s) (See Table 2):

| Code | Hours per Week in Mass. | |
|---|---|---|
| OBG | 4 | Obstetrics and Gynecology |
| | 0 | |

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

**Corrections of Pre-Printed Information**

Name:
Address (Home):
City/Town:
State: Zip:
Country Code: 0 If 999 print Country:
Address (Business): Harvard Community Health Plan
City/Town: 400 Bald Hill Rd, Warwick, RI 02886
Country Code: 0 If 999 print Country:

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

VT RI
CA OR

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

Code: Code:

Code: Code:

Federal (DEA):
State (MA):

9. I have completed my CME requirements in the two years preceding my renewal date: Yes 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: Williams Registration Number: 60391

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: CRICO - Controlled Risk Insurance Co, LTD.

*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: 057 / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)
   Facility Code: 998 / ✓ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

   If 999, print name(s): ___

   Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)
   Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
   If 999, write name(s): Women & Infants Hospital Providence RI
   Miriam Hospital, Providence RI

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) 40
   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? 4 hrs/wk in MA
      ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 0 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.**

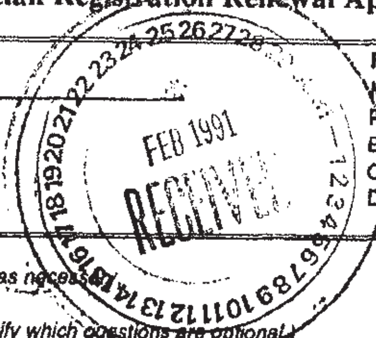
- **I hereby certify under the penalties of perjury that all information on this form and Form 15A is true.**

Signature: Robert R Williams Date: 2,24 93

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

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 60391 | ACTIVE | $150 | 03/04/91 |

Dr. ROBERT R WILLIAMS




For Office Use Only
M.R.
Rr.
Bk. FEB 25 1991
Ch.
D.E.

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

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

**Pre-Printed Information** — **Corrections of Pre-Printed Information**

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

2. a) Address (Home):
   Address:
   City/Town:
   State: Zip:
   Country Code: 0 (If 999 write Country):

2. b) Address (Business):
   RHODE ISLAND GROUP
   400 BALD HILL ROAD
   WARWICK, RI 02886-
   Address: Rhode Island Group Health Assn.
   City/Town: 400 Bald Hill Road Warwick
   State: R.I. Zip: 02886
   Country Code: 0 (if 999, write Country):

3. Date of Birth: Sex: M
   Lic. Issue Date: 09/26/88 SSN #:
   Telephone Number:
   Home
   Business (401)732-0300
   Date of Birth (M/D/Y): ___/___/___ Sex (M/F):
   Lic. Issue Date(M/D/Y): ___/___/___ SSN #:
   Home: (___) Business: (___)

4. Medical School Code: QU001 Year Graduated: 68 Degree: MD
   Name of School:
   Faculty of Medicine, McGill University
   School Code: Year Graduated: Degree (MD/DO):
   If 99999, write School:

5. a) Other States where you are now licensed to practice (*Abbr*): VT OR RI
   b) States where you previously were licensed to practice (*Abbr*): CA

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

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

| Code | Hours per Week in Mass. |
|---|---|
| OBG | 4 |

If OS, write specialty:

7.a) Are you American Specialty Board Certified? (Y/N) Y 7.b) If YES, Enter Codes:
   Code: OG Board of Obstetrics and Gynecology
   Code:
   Code:
   Code:

8. Drug License Number(s) (if any) [optional]: a) Federal (DEA)____ b) How many DEA nos. do you have? One
   c) State (MA) #M NA

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

30M - 9/90 - P813971

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

FILL IN NAME AND NUMBER:

Physician Last Name: WILLIAMS Registration No.: 60391

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

List Insurer: Prior To Dec 1990 - RI. JUA, From Dec 1990 on ICRICO - Controlled Risk Insurance Co. LTD

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

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

*(State how otherwise exempt)*:_____

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

Facility Code: 998 / ✓ (AP) Facility Code: ____ / __ (AP) Facility Code: ____ / __ (AP)

Facility Code: 998 / ✓ (AP) Facility Code: ____ / __ (AP) Facility Code: ____ / __ (AP)

*If 999, write* Name(s):_____

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

NA. Facility Code:____ Facility Code:____ Facility Code:____ Facility Code:____

*If 999, write* Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

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

NA b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow____ or iii) Research Fellow____? (Check one.)

NA c) How many hours per typical week do you spend in this MA post-graduate training program?____hrs./wk. in MA.

13. *Care of Patients in Massachusetts (MA) (See instruction booklet.)*

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 4 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 0 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? *(See Table 6)* 40

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

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

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

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

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

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

Signature: Robert R Williams Date 2 / 18 / 91

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

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

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Robert T Raymond Williams HOSPITAL: Women & Infants Hospital of RI
PERMANENT ADDRESS:
ADDRESS: 101 Dudley ST. Providence RI 02905
LOCAL MAILING: SAME

ADDRESS IN (MA): Rhode Island Group Health Assn.
1010 GAR Highway
Swansea, MA. 02777

**YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.** YES N

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

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

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

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

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

SIGNATURE: Robert R Williams MD DATE: 8-19-88

(Robert Raymond Williams)

# Commonwealth of Massachusetts Board of Registration in Medicine

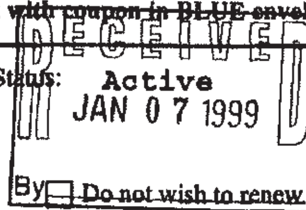
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

# 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.: 60391   Renewal Date: 03/04/1999   1. Current Status: Active

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

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

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

3. A) Mailing/Home Address:

ROBERT R WILLIAMS, M.D.

B) Business Address:

#1 HARVD PILGRM HEALTH CARE
400 BALD HILL ROAD
WARWICK, RI 02886

Also #2 →

Home Phone: ( ) -
Business Phone: (401)732-0300

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

5. A) Name of Medical School:
   McGill University Faculty of Medicine
   B) Year Graduated: 1968   C) Degree: MD

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

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

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

Other Name(s): ______

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

Other Address: Harvard Pilgrim Health Care 60 Messenger ST.
City/Town: Plainville State: MA
Zip: 02762 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:   Also → #2
   #1 A) Federal (DEA):
   B) Massachusetts:

Federal (DEA)
Mass.: ______

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

Abbr: ______
Abbr: ______

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

60391

PRINT NAME AND NUMBER: Last Name: Williams Registration Number: 60391

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

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

If 999, print name(s): Women & Infants Hospital of RI - 100% Miriam Hospital 0% Both in Providence

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

Name of Insurer: Controlled Risk Ins. Co. of Vermont 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) 40 10

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? 0 %

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

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

| Question | YES | NO |
|---|---|---|
| 14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim? | | |
| 15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim? | | |
| 16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or been settled, adjudicated or otherwise resolved? | | |
| 17. Have you been charged with any criminal offense, other than a minor traffic violation? | | |
| 18. Have you been 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: Robert R Williams MD Date: 1/12/99

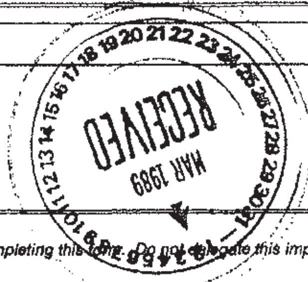
**YOU MUST SIGN AND INCLUDE PART B, PAGE 3, WITH YOUR RENEWAL APPLICATION**

**Commonwealth of Massachusetts Board of Registration in Medicine**
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
**1989-1991 Physician Registration Renewal Application, Page 1 of 2**

**Board Use Only:**

| Registration No. | Status | Fee | Renewal Date |
|---|---|---|---|
| 60391 | 1 | $150 | 03/04/89 |

ROBERT RAYMOND WILLIAMS




M.R.
Pr. 3/6/89
Bk.
Ch.
D.E.
Fl.

**Important:**
. *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
. *Print legibly or type your answers.*
. *Answer all non-optional questions (front and back of form) completely*--**It is not adequate to state that the Board already has the information.**
. *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
. *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
. *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) WILLIAMS (FIRST:) ROBERT (M.I.:) R.
1. b) Other Name(s), if any, that you were ever licensed under:
2. a) Address (Mailing):
2. b) Address (Home): same as 2a.
2. c) Address (Business): Rhode Island Group Health Assn. 400 Bald Hill Road, Warwick RI 02886
2. d) Telephone (Business): (401) 732-0300 Extension 281 2. e) Telephone (Home) *(Optional)*:
3. Date of Birth (MO/DA/YR): 4. Sex: MALE X FEMALE ___ 5. Social Security No. *(Optional)*:
6. a) Medical School Code *(See Table 1)*: QU001 *If 99999, write Name*:
6. b) Year Graduated: 1968 6. c) Degree: M.D. X D.O. ___
6. d) Country: U.S. ___ Canada X Code if Other *(See Table 2)*: ___ *If 999, write Name*:

7. Work Setting *(Circle and indicate Percent(%) of Practice Time)*:

| | | | | | |
|---|---|---|---|---|---|
| 10 Hospital | 35 % | 15 Private Office | % | 20 Partnership/Group Practice | % |
| 25 Clinic | % | 30 Mental Health Center | % | 35 Nursing Home | % |
| 40 HMO Facility | 65 % | 45 Educational Institution | % | 50 Medical Society | % |
| 55 Government Facility | % | 60 Plant/Commercial Setting | % | 99 Other | % |

8. Professional Activity *(Circle and indicate Percent(%) of Professional Time)*:

| | | | |
|---|---|---|---|
| 10 Resident or Fellow | % | 20 Practice Involving Direct Patient Care | 95 % |
| 30 Administrative Activities | 1 % | 40 Medical Teaching | 4 % |
| 50 Medical Research | % | 99 Other | % |

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 9/28/88

9. Specialty Code *(See Table 3)*: OBG Percent of Practice Time: 100% Specialty Code: ___ Percent of Practice Time: ___%
*If OS, specify*:

10. a) Are you American Specialty Board Certified? (Y/N) Y 10. b) *If YES, circle which Board(s)*:

| | | | | | |
|---|---|---|---|---|---|
| AI | Board of Allergy & Immunology | NM | Board of Nuclear Medicine | PS | Board of Plastic Surgery |
| A | Board of Anesthesiology | (OG) | Board of Obstetrics & Gynecology | PM | Board of Preventive Medicine |
| CRS | Board of Colon & Rectal Surgery | OP | Board of Ophthalmology | PN | Board of Psychiatry & Neurology |
| D | Board of Dermatology | OS | Board of Orthopedic Surgery | R | Board of Radiology |
| EM | Board of Emergency Medicine | OT | Board of Otolaryngology | S | Board of Surgery |
| FP | Board of Family Practice | PA | Board of Pathology | TS | Board of Thoracic Surgery |
| IM | Board of Internal Medicine | PE | Board of Pediatrics | U | Board of Urology |
| NS | Board of Neurological Surgery | PMR | Board of Physical Medicine & Rehabilitation | | |

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*
Facility Code: 998 35 % Facility Code: ___ ___% Facility Code: ___ ___%
Facility Code: 429 65 % * Facility Code: ___ ___% Facility Code: ___ ___%
*If 999, write Name(s)*: *Note - Only 6% of my time is spent at a RIGHA facility in Mass - The rest of RIGHA facilities in RI or in Hospitals in RI

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*
Facility Code: 998 Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___
*If 999, write Name(s)*:

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

**Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.**

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

**I hereby certify under the penalties of perjury that all information on this form--front and back and (#) 0 attached pages--is true.**

Signature: Robert R Williams (see reverse side) Date: 2/28/89

**Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2**

*Fill in name and number.* **Physician Last Name:** WILLIAMS **Registration No.:** 60391

12. a) Other States where you are now licensed to practice (*Abbreviate*): VT OR RI

12. b) States where you previously were licensed to practice (*Abbreviate*): CA

13. I am applying to be registered with the following status: ACTIVE X *INACTIVE___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)* Category I: 169 hrs., Category II: 40 hrs., (Risk-Management: 14 hrs.); *Residency Program In:* ___; Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER X LETTER OF CREDIT___. *If applicable, check one and identify the name.* Insurer: Frank B. Hall - Providence RI Institution Issuing Letter of Credit: ___
*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___ OTHERWISE EXEMPTED___ *(State how)* ___

14. c) Percent of Practice Time in Massachusetts: 6[illegible] % = 6%

*Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached.* **Yes No**

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

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

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

**If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.**

************************************************************

*Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section.* **Yes No**

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

19. *Have you withdrawn an application for a medical license or been denied a medical license for any reason?* ............

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

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

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

23. Have you, for any reason, lost American Specialty Board Certification? ............

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ............

# Massachusetts Physician Renewal Application

**Physician Name:** Robert R Williams  **License No.:** 60391

## PART A

**1) Current Status:** Active  **Renewal Due Date:** 02/04/2005  **Birth Date:**

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

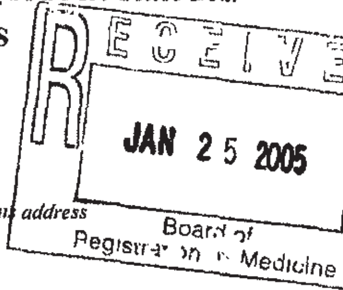
☐ Active ☐ Retiring ☐ Inactive ☐ Do not wish to renew

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

***Please make corrections*** (print)

**2a) MAILING ADDRESS**
Women's Care Inc.
118 Dudley St.
Providence, RI 02905

☐ *Check here to change this address*




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

**2b) HOME ADDRESS**

Phone:

☐ *Check here to change this address*

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

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**
Women's Care Inc.
118 Dudley St.
Providence, RI 02905

Phone: ~~(401)272-0521~~

☒ *Check here to change this ~~address~~* Phone#

Business Address: ____
City/Town: ____ State: ____
Zip: ____ Country: ____
Business Telephone: (401) 727 4800

*Business address cannot be a Post Office Box*

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

**4) Fax Number:** 401 273 5815

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

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

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

| Board Name | ABMS | AOA | Certificate/Subspecialty | Correct? | Delete? |
|---|---|---|---|---|---|
| Obstetrics & Gynecology | ☒ | ☐ | Obstetrics & Gynecology | ☒ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |
| | ☐ | ☐ | | ☐ | ☐ |

# Massachusetts Physician Renewal Application

**Physician Name:** Robert R Williams **License No.:** 60391

✓

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

**9) What is your principal work setting?** *(See Renewal Instructions, page 4.)*
Principal Work Setting: ~~HMO~~
Change to: Partnership/Group Hours per Week: 50

**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 Hospital-Providence | ☐ | X | | 30 |
| Rhode Island Hospital | ☐ | X | | 0 |
| Planned Parenthood of RI | ☐ | NA | | 4 |
| | ☐ | | | |
| | ☐ | | | |
| | ☐ | | | |

**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)* Women & Infants Indemnity Program
Current Insurance Carrier: Providence RI Change to: ____________

Policy dates: From 7/1/04 To 6/30/05
*(required)*

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

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

Check one:

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

# Massachusetts Physician Renewal Application

**Physician Name:** Robert R Williams **License No.:** 60391

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

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

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

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

**22) CME CERTIFICATION:**

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

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

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

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

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

# Massachusetts Physician Renewal Application

Physician Name: Robert R Williams    License No.: 60391

## PHYSICIAN PROFILE

☒ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate. I do NOT have one,

☐ 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.*)

I wish to keep an Active Status in case I need to cover an MD at our Swansea office,

## 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.

But I have Not Practiced in Mass in Past 3 years,

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: Robert R Williams MD    Date: 1/15/05

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

✓

MA License Number: 60391
Date license revived: ___/___/___

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

# LAPSED LICENSE APPLICATION

JUL 26 2004

**Application Fee:** Please enclose a check or money order in the amount of $600.00 in U.S. currency, made payable to the Commonwealth of Massachusetts.

**Activity Status:** ☒ Active ☐ Inactive*

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

Williams Robert R

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

**Medical Degree:** ☑ M.D. ☐ D.O. ☐ Ph.D. ☐ Other degree___________

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

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

Date of Birth: ________ Social Security Number: ________
Month Day Year

Place of Birth: WILLITS, California, USA
City State/Province/Territory Country if not USA

Home Address: ____________________
Number and Street

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

Business Address: 1162 GAR HIGHWAY
Number and Street

Swansea MA 02777
City State/Province/Territory Zip (or postal) Code

Business Telephone: (401) 727 4800, ext. ________ Home Telephone:

Preferred Mailing Address: ☐ Business Address ☒ Home Address

Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No

*Inactive status: If you check inactive status when you sign the lapsed application, you certify that you will not practice medicine in Massachusetts.

APPLICANT'S NAME: Robert Williams

**Postgraduate Education:**

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

| Facility | Street | City | State | Position | From | To |
|---|---|---|---|---|---|---|
| McGill Medical School | Montreal | | Quebec | Student | Sept 64 | June 68 |
| Chelsea Naval Hospital | | Chelsea | MA | Intern | July 68 | June 69 |
| US Navy | Various locations | | | General Medical Officer | July 69 | June 72 |
| Women & Infant's Hospital | Dudley | Providence | RI | Resident | July 72 | June 75 |
| | | | | | / / | / / |

**Hospital Affiliations and Employment**

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

Hospitals

| Facility | Street | City | State | Position | From | To |
|---|---|---|---|---|---|---|
| Womens Infant's Hospital | Dudley | Providence | RI | Active Staff | 1972 | Present |
| Columbia District Hospital | | St. Helens | Oregon | Active Staff | July 79 | June 80 |
| North Country ~~Newport~~ Hospital | | Newport | VT. | Active Staff | July 80 | Oct 84 |
| Miriam Hospital | 5th Street | Providence | RI | Active Courtesy Staff | 1987 | Dec 1999 |

Robert R Williams

**Hospital Affiliations and Employment**

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

Hospitals Cont.

From | To

Facility: Rhode Island Hospital Position: Active Staff, 1996, Present
Street: Dudley City: Providence State: RI

Employment
Facility: Employed by Fred Ripley MD Position: Associate, July 75, June 76
Street: Waterman City: Providence State: RI

Facility: RI Group Health Assn. Position: HMO Employee July 76 June 79
Street: North Main ST City: Providence State: RI

Facility: Columbia District Hosp. Position: Group Practice July 79, June 80
Street: City: ST Helens State: Or

---

**Hospital Affiliations and Employment**

List in chronological order all hospital appointments where you had active staff privileges, including the name and address of the facility, your position and dates of affiliation in postgraduate training. Also include periods of unemployment or employment outside of medicine. Do not include postgraduate training facilities. Attach a separate sheet of paper if necessary.

Employment Cont

From | To

Facility: North Country Hospital Position: Group Practice July 80 Oct 84
Street: City: Newport State: VT

Facility: RI Group Health AssN Position: HMO Employee Nov 84, Dec 1990
Street: North Main ST City: Providence State: RI

Facility: Harvard Pilgrim Health Care Position: HMO Employee, Jan 91, Dec 99
Street: Hoppin ST City: Providence State: RI

Facility: Solo Private Practice Position: OB GYN Jan 2000, April 03
Street: Dudley City: Providence State: RI

Facility - Womens Care Inc. Group Practice May 2003 → Present
Dudley ST. Providence RI

CS21000160
47

APPLICANT'S NAME: Robert Williams

**Medical Malpractice Information:**

My medical malpractice insurance coverage is by: ☒ Insurance carrier ☐ Letter of Credit

Print name of insurer: Women & Infants Hospital Indemnity

Policy dates: From: 1 Jan 04 To: 31 Dec 04

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because: ☐ I am not involved in direct patient care ☐ Otherwise exempt

Explain exemption: ______

**Continuing Medical Education Credits**

Read instructions for continuing medical education requirements before completing.

Activity status: ☒ Active ☐ Inactive ☐ Exemption ______

Category 1 credits 110 Category 2 credits 2 Risk management Category 1 12 Category 2 2

Continuing medical education credit requirements must be completed before the Lapsed License can be revived.

1. List other states (abbreviations) where you are currently or have ever been licensed: RI VT CA OR
2. Are you certified by the American Board of Medical Specialties (ABMS)? ☒ Yes ☐ No
3. List only ABMS certification(s): OB-GYN 1979 1994
4. Reason for reviving Lapsed License in Massachusetts: I'm an employee of a Company That has an office in Swansea - MA - Womens Care, Inc.

**Affidavit of Applicant**

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

Robert R Williams MD 5-24-04

Signature of Applicant Date

## SUPPLEMENT FORM FOR LAPSED APPLICATION

PRINT NAME: Robert Williams DATE: 5/24/04

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

**QUESTIONS** **YES** **NO**

1-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?

1-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

2. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?

3-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).

3-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association ( national, state or local)?

4-A. Have you ever voluntarily relinquished any medical staff membership?

4-B. Has your medical staff membership, medical privileges or medic al staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?

4-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?

4-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?

5. Have you ever been charged with any criminal offense, other than a minor traffic offense?

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

Signed: Robert Williams MD Date: 5-24-04

| | | YES | NO |
|---|---|---|---|
| 7. | Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider? | | |
| 8. | Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs? | | |
| 9. | Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan? | | |
| 10-A. | In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim? | | |
| 10-B. | In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved? | | |

Applicant's Signature: Robert Williams MD Date: 5/24/04

November 14, 2003

# CURRICULUM VITAE
# ROBERT RAYMOND WILLIAMS

## PERSONAL INFORMATION

Date of Birth:
Place of Birth: Willis, California
Citizenship: U.S.A.
Social Security Number:
Marital Status: Married

Home Address:

Business Address: Women's Care, Inc.
118 Dudley Street
Providence, RI 02905
Business Telephone Number: (401) 727-4800
E-Mail Address:

## EDUCATION

1959-1960 Moody Bible Institute, Chicago, IL
General Study of the Bible
1960-1964 University of California, Davis, CA
B.A. in Zoology, 1964
1964-1968 McGill University, Montreal, Quebec, Canada
M.D., 1968

## POSTGRADUATE TRAINING

1968-1969 Chelsea Naval Hospital, Chelsea, MA
Rotating Internship
1972-1975 Women and Infant's Hospital of R.I., Providence, RI
Residency in OB/GYN (Affiliated with Brown University)

## MILITARY SERVICE

1968-1972 U.S. Navy
1968-1969 Internship
1969-1970 Ship's Physician-Nuclear Submarine
USS Thomas Edison-Gold Crew
1970-1972 General Medical Officer (LCDR, USNR)
Quonset Naval Hospital, Quonset Point, RI
1986-1988 Major RI Air National Guard
143rd Hospital Unit, Quonset Point, RI

## PROFESSIONAL LICENSES AND BOARD CERTIFICATION

1970-Present Rhode Island Medical License
1979 Board Certified-American Board of OB/GYN
1994 Board Re-certified-American Board of OB/GYN

## ACADEMIC APPOINTMENTS

1974-1975 Teaching Fellow-OB/GYN-Brown University
1976-1979 Clinical Instructor-OB/GYN-Brown University
1983-1984 Clinical Associate Professor-OB/GYN-University of Vermont College of Medicine, Burlington, Vermont
1985-1988 Clinical Instructor-OB/GYN-Brown University
1988-Present Clinical Asst. Professor-OB/GYN-Brown University

## HOSPITAL APPOINTMENTS

1975-1979 Women and Infant's Hospital of RI, Providence, RI*
1979-1980 Columbia District Hospital, St. Helens, OR*
1976-1979 Rhode Island Hospital, Providence, RI**
Asst. Director, Adolescent Gynecology Clinic
1979-1984 Women and Infant's Hospital, Providence, RI
Courtesy Privileges in OB/GYN
1980-1984 North Country Hospital, Newport, VT*
Chief-Dept. of OB/GYN
1984-Present Women and Infant's Hospital of RI, Providence, RI*
1989-1999 Miriam Hospital, Providence, RI
Courtesy Privileges in GYN
1995-Present Rhode Island Hospital, Providence, RI**

## HOSPITAL COMMITTEES

1975-1976 Fetal Surveillance Task Force (Chairman)
Planned remodeling of Labor Suite, Women and Infant's Hospital
1980-1984 Executive Committee, NCH
1985-1989 Medical Records Committee, WIH (Chairman in 1988)
1985-1990 Bylaws Committee, WIH
1991-1993 Perinatal Mortality Committee, WIH (Co-Chairman in 1993)
1988-1994 Chairman of WIH Annual Hospital Dinner Dance
1994-1996 OB Review Committee
1997-2001 Resident Evaluation Committee
2000-Present Executive Committee WIH, Providence, RI
2001-Present Finance Committee, WIH, Providence, RI

**Full Staff Privileges in OB/GYN*
***Full Staff Privileges in GYN*

MEMBERSHIP IN SOCIETIES

1970-1979 and 1987-Present: RI Medical Society
1979-Present Fellow-American College of OB/GYN
1992-1996 Committee Member, RIMS M.D. Health Committee
(Formerly "Impaired Physician Committee")

PUBLICATIONS

Charache S, Catalano P, Burns S, Jones RT, Koler RD, Rutstein R, and Williams RR: *"Pregnancy in Carriers of High-Affinity Hemoglobin's Blood"*, Vol 65, No3, March 1985: pp713-718

Williams RR: Supracervical Abdominal Hysterectomy: *"A Technique Whose Time Has Come (Again!)."* Medicine & Health/Rhode Island, Vol 82, No.10 October 1999: pp359-361.

UNIVERSITY TEACHING ROLES

EFM LECTURES

1975-1979 and 1986-1996 On a regular basis I gave a one-hour lecture on Electronic Fetal monitoring to the Brown University Medical Students as they rotated through Women & Infant's Hospital. I gave these lectures to approximately 1,300 Medical Students over 20 years.

ONE-MONTH PRECEPTORSHIP

1983-1984 Twice during this period I arranged for Medical Students from the University of Vermont College of Medicine to spend one month with me in Newport Vermont, doing an elective OB/GYN. This was arranged to give students a firsthand view of what the practice of OB/GYN is like, living in "small town" America.

PRECEPTOR FOR BROWN UNIVERSITY MEDICAL STUDENTS

1985-Present I have had anywhere from two to six students per year for six weeks preceptor ships in OB/GYN (depending on whether I had a longitudinal student that year).

LONGITUDINAL STUDENT PRECEPTOR

1994-Present: I have had six Brown University Medical Students do a six-month longitudinal preceptor ship with me. During the six months these students spent one half day per week seeing patients with me in my office.

2321041263

## RESIDENT PRECEPTOR

| | |
|---|---|
| 1975-Present | I have served as preceptor for residents perhaps eight times over the pass 22 years. |

## AWARDS

| | |
|---|---|
| 1969 | Intern of the year. Chelsea Naval Hospital, Chelsea, MA |
| 1991 and 1996 | Brown University Medical Student Preceptor of the Year in OB/GYN |
| 1999 | Newsweek Magazine: Harvard Pilgrim Health Care #1 HMO in America. For Quality Medical Care and Patients Satisfaction. |
| 2000-2001 | Voluntary Faculty Top Teacher of the Year Award for Medical Students. Department of OB/GYN WIH |
| June 2001 | Voluntary Faculty Top Teacher of the Year Award for Residents Department of OB/GYN WIH |
| June 2001 | Brown Medical School Dean's Award for Exemplary and Meritorious Service in Teaching Obstetrics and Gynecology at Brown University. |

## WORK EXPERIENCE IN THE PAST FIFTEEN YEARS

| | |
|---|---|
| 1984-1999 | Staff Physician in OB/GYN, Harvard Pilgrim Health Care of NE (formerly RIGHA), 400 Bald Hill Road, Warwick , RI 02886 |
| 2000-4/2003 | Private Solo Practice of OB/GYN<br>120 Dudley Street, Suite 301, Providence, RI 02905 |
| 5/2003-Present | Staff Physician in OB/GYN, Women's Care, Inc.,<br>118 Dudley Street, Providence, RI 02905 |

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

## MALPRACTICE HISTORY

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

**Waiver for Release of Information**

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

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

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

Liability Carrier: Women & Infants Indemnity From: 1 Dec 99 To: 31 Dec 04
City: Providence State: RI Policy Number: WIH/091

Liability Carrier: Crico From: 1 Jan 91 To: 31 Dec 99
City: Burlington State: VT Policy Number: CRV 10024 HPHC-0001

Liability Carrier: Joint Underwriters Assn From: 1 Nov 84 To: 31 Dec 1990
City: Providence State: RI Policy Number: JUA 18645

Applicant's signature: Robert R Williams MD Date 5, 24, 04

Print Name: Robert R Williams MD

Address: ______ City: ______

State: ______ Zip code: ______

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

see list of additional JUA policy numbers.

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See list of additional JUA policy numbers.

# Massachusetts Physician Renewal Application

**Physician Name:** Robert R Williams, M.D. **License No.:** 60391

**PART A**

1) **Current Status:** Active **Renewal Due Date:** 02/04/2007 **Birth Date:**

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

Active ☐ Retiring ☐ Inactive ☒ Do not wish to renew

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

**Please make corrections** (print)

**2a) MAILING ADDRESS**

RECEIVED

☑ *Check here to change this address*

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

**2b) HOME ADDRESS**

Phone:

☑ *Check here to change this address*

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

*Home address cannot be a Post Office Box*

**2c) BUSINESS ADDRESS**
Women's Care Inc.
118 Dudley St.
Providence, RI 02905

Phone: (401)727-4800

☑ *Check here to change this address*

Business Address: 407 East Ave
City/Town: Pawtucket State: RI
Zip: 02860 Country: USA
Business Telephone: (401) 727 4800

*Business address cannot be a Post Office Box*

**3) E-mail Address:**

**4) Fax Number:** 401-273-5815

**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 | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |



Robert R Williams MD