

REDACTED COPY

Application #: 213320
Date of Issue: _____



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

FULL LICENSE APPLICATION

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

Check One: ☒ U.S./Canadian Graduate ☐ International Graduate

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

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

☒ M.D. ☐ D.O. ☐ Ph.D. ☐ Other degree _____

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

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

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

Place of Birth: Boston MA
City State/Province/Territory Country if not USA

Home Address: _____
Number and Street

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

Business Address: Dept. of Family Medicine 111 Brewster St.
Number and Street

Pawtucket RI 02860
City State/Province/Territory Zip (or postal) Code

Business Telephone: (401) 729-2206 ext. _____ Home Telephone: _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

#429

12/11/01

PRINT NAME: Melissa Brooks Nothnagle PAGE 2 OF 3

Pre-medical School

Facility: Brown University Degree: BA From 9/15/89 To 5/25/93
Street: Prospect St. City: Providence State: RI

Facility: Rhode Island College Degree: none From 1/15/94 To 12/20/94
Street: 600 Mt. Pleasant Ave City: Providence State: RI

Medical School

Facility: Univ of California San Francisco Degree: MD From 9/20/95 To 6/13/99
Street: 513 Parnassus Ave City: San Francisco State: CA

Facility: _____ Degree: _____ From _____ To _____
Street: _____ City: _____ State: _____

Date of medical school graduation: 6/13/99

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

Postgraduate Education:

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

Facility: Memorial Hospital Position: PGY 1 From 6/24/99 To 6/30/00
Street: 111 Brewster St. City: Pawtucket State: RI

Facility: Memorial Hospital Position: PGY 2 From 7/1/00 To 6/30/01
Street: 111 Brewster St. City: Pawtucket State: RI

Facility: Memorial Hospital Position: PGY 3 From 7/1/01 To 6/28/02
Street: 111 Brewster St. City: Pawtucket State: RI

Facility: _____ Position: _____ From _____ To _____
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ From _____ To _____
Street: _____ City: _____ State: _____

PRINT NAME: Melissa Brooks Normnagle

PAGE 3 OF 3

Hospital Affiliations and Employment

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

	<u>From</u>	<u>To</u>
Facility: <u>see postgraduate education</u>	Position: _____	_____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	_____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	_____
Street: _____	City: _____	State: _____
Facility: _____	Position: _____	_____
Street: _____	City: _____	State: _____

1. List other states (abbreviations) where you are currently or have ever been licensed: _____

2. Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No

3. List Board Certification(s): _____

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

5. Reason for requesting a Massachusetts medical license: Seeking work in Mass.
after graduation, need license to sit for Family Medicine Boards.

6. Name of Facility: _____

7. Address: _____ City: _____

8. Anticipated starting date in Massachusetts: ____/____/____

Affidavit of Applicant

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



Signature of Applicant

12/2/01

Date

MELISSA BROOKS NOTHNAGLE, MD

EDUCATION

Residency
June 1999- June 2002

Family and Community Medicine, Brown University
Memorial Hospital of Rhode Island
Chief Resident, 2001-2002

Medical school
Sept 1995 - May 1999

University of California, San Francisco
Doctor of Medicine

Undergraduate
Sept 1989 - May 1993

Brown University, Providence, RI
Bachelor of Arts, *magna cum laude*, in Psychology; minor in Visual Arts

June 1993 - Dec 1994

Brown University, Providence, RI
Rhode Island College, Providence, RI
Additional premedical courses

EMPLOYMENT

June 1996 - Aug 1998

Research Assistant
Dept. of Family and Community Medicine
University of California San Francisco
Literature review, data analysis, manuscript preparation on access to
prenatal care for low-income women

June 1993 - Aug 1995

Research Coordinator
Dept. of Pediatrics, Brown University
Supervised data collection and analysis for studies of adolescent mothers
and their children

June 1992 - July 1995

Research Assistant
Child Development Center, Dept. of Pediatrics, Brown University
Collected and analyzed data on language development of infants with
Down syndrome

ORGANIZATIONS

Advisory Board Member, Rhode Island Academy of Family Physicians
Resident Coordinator, Brown University Family Medicine Interest Group
American Academy of Family Physicians

PUBLICATIONS

Nothnagle, M, Marchi, K, Egarter, S, and Braveman, P. Risk factors for
late or no prenatal care following Medicaid expansions in California.
Maternal and Child Health Journal 2000; 4:251-259.

HONORS AND AWARDS

MacKenzie Foundation Scholarship for primary care, 1998-1999

SKILLS

Fluency in Spanish
Elective experiences in colposcopy, obstetrics, and first trimester abortion

CERTIFICATION

ACLS provider, certified through June 2003
Advanced Life Support for Obstetrics, June 2001
Neonatal Resuscitation Program, July 2001

SUPPLEMENT FORM

PRINT NAME: Melissa Brooks Northnagle DATE: 12/2/01

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

YES NO

1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?

2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?

3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____

4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?

5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?

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

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

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

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

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

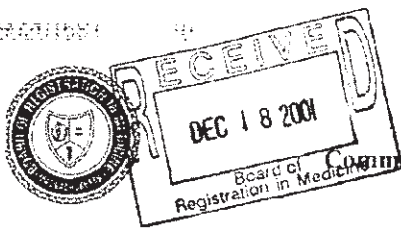
PRINT NAME: Melissa Brooks Nornagle

Page 5

YES NO

- 9-A. Have you ever voluntarily relinquished any medical staff membership?
- 9-B. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
- 9-C. Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?
- 9-D. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
10. Have you ever been charged with any criminal offense, other than a minor traffic offense?
11. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?
12. Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?
13. Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?
14. Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?
- 15-A. In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim?
- 15-B. In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled, adjudicated or otherwise resolved?

Applicant's Signature:  Date: 12/2/01



FULL LICENSE APPLICANT

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

MEDICAL EDUCATION VERIFICATION

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

Waiver for Release of Information

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

Applicant's Signature: _____ Date of Birth: _____

Print or Type Name: Nothnagle Melissa B Social Security No. _____
(Last name) (First Name) (Middle Initial)

Other Name(s): _____
(Please type or print name(s))

Name of Medical School: University of California San Francisco School of Medicine

Address: 513 Parnassus Ave City: San Francisco State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No
if yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Brown University

Undergraduate School Address: Providence, RI
Continued on

NOTHNAGLE MELISSA B
(type or print the applicant's name) (Last name) (First name) (Middle initial)

back

Handwritten signature/initials

FULL LICENSE APPLICANT

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	9 / 4 / 95	6 / 15 / 96	7 / 1 / 98	6 / 13 / 99
	9 / 1 / 96	6 / 30 / 97		
	7 / 1 / 97	6 / 30 / 98		

The applicant attended 33-48 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

check one ☒ was awarded a degree in Medicine on (month/day/year) 6 / 13 / 99

☐ was NOT awarded degree. Please explain reason(s): _____

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

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Maxine Papadakis

Print Name: Maxine Papadakis, MD

Title: Associate Dean

Date: 12 / 12 / 01 Telephone: (415) 476.1216



DEC - 6 2001

BOARD OF REGISTRATION
IN MEDICINE

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

POSTGRADUATE VERIFICATION

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [Signature] Date: 11/30/01

Print or Type Name: Melissa B. Nothnagle

Name of Institution: Brown University Dept of Family & Community Medicine

INSTRUCTIONS TO THE PROGRAM DIRECTOR

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

Name of Institution: Brown Medical School / Memorial Hospital of Rhode Island

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

Enrollment and Participation: Our records indicate that Melissa B. Nothnagle, MD participated in the following program:
(type or print applicant's name)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO:		
Residency	PGY 1	Fam Med	6'24'99	6'30'00	Yes	ACGME
Residency	2	Fam Med	6'30'00	6'30'01	Yes	ACGME
Residency	3	Fam Med	6'30'01	6'30'02	Anticipated	ACGME
			1 1	1 1		
			1 1	1 1		

POSTGRADUATE VERIFICATION

Continued on back

APPLICANT'S NAME: Melissa B. Northhagle

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

QUESTIONS

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?
6. During the applicant's participation, our postgraduate medical training ☒ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: _____

Print Name: John Murphy MD

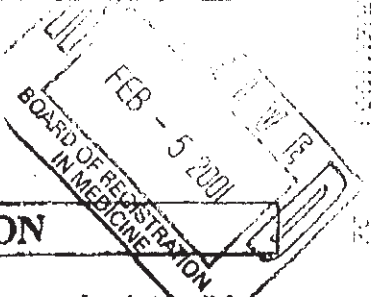
Academic Title: Residency Director, Professor

Telephone: (401) 229 2236 Today's Date: 12, 03, 01

DATE 2/14/01
INITIAL CM
FEE: \$50.00 CHECK
CK# 294

Application #: 210206
Date Approved: _____

Commonwealth of Massachusetts
Board of Registration in Medicine
10 West Street, Boston, Massachusetts 02111



INITIAL LIMITED LICENSE APPLICATION

IMPORTANT: Read the accompanying instructions before completing this form, and print legibly or type your answers. Please attach a \$50 check payable to the Commonwealth of Massachusetts.

CHECK ONE:

- ☐ Graduate of a Medical School in the United States, Canada, or Puerto Rico (USMG)
☐ Graduate of an International Medical School (IMG)
☐ Graduate of an International Medical School applying under the Special Refugee Physician Program

NOTE: GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS

SECTION A: Sworn Statement to be Completed by Applicant

- 1-A. Name: (Last) NOTHNAGLE (First) MELISSA (MI) B
1-B. Other Name(s): _____
1-C. Mother's Maiden Name: O'CONNOR Social Security No _____

- | | YES | NO |
|---|--------------------------|-------------------------------------|
| 1) Have you ever been known under a different name or combination of names? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 2) Have you ever been licensed under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| 3) Have you ever applied for licensure, or applied to sit for an examination, or taken an examination under a different name? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

If yes, you must provide additional information. (See instructions.)

2. Current Residence: _____ Telephone Number: _____
City: _____ State: _____ Zip: _____
3. Date of Birth: _____ Place of Birth: BOSTON, MA
(Month) (Day) (Year)
4. Sex: ☐ Male ☒ Female 5. Social Security Number: _____
6. Name of Massachusetts Training Hospital: Boston Medical Center
1 Boston Medical Center Place Boston, MA
(Street Address) (City)

NAME: MELISSA NOTHNAGLE MD

Page 2 of 6

7. Name of premedical school(s): BROWN UNIVERSITYLocation: PROVIDENCE, RI & USA
(City, State, Country)8. Name of medical school(s): UNIV. of California, San FranciscoLocation: San Francisco, CA U.S.A.
(City, State, Country)Date of Graduation: 5 / 199 Degree: ☒ M. D. ☐ D. O. Other(specify) _____
(Month) (Day) (Year)9. Have you had previous post-graduate training? ☒ No ☐ Yes ☐ U.S. or ☐ International

Name of Institution: _____

Address: _____

Name of Program: _____ Dates of Training: _____
(If additional space is needed, please continue your answer on a separate sheet of paper.)10. List states (abbreviations) where you are currently licensed to practice medicine (include residency training licenses). Indicate whether full license (F) or residency or limited license (L).RI ☐ (F) ☒ (L) _____ ☐ (F) ☐ (L) _____ ☐ (F) ☐ (L) _____ ☐ (F) ☐ (L)11. List states (abbreviations) where you were previously licensed to practice medicine (include residency-training licenses). Indicate whether full license (F) or residency or limited license (L)._____ ☐ (F) ☐ (L) _____ ☐ (F) ☐ (L) _____ ☐ (F) ☐ (L) _____ ☐ (F) ☐ (L)**YES NO**12-A. If you are a USMG, have you taken more than 4 years to complete medical school?12-B. If you are an IMG, have you taken more than 6 years to complete medical school?
If yes, you must provide additional information. (See instructions).13. Has more than one year passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts?
If yes, you must provide additional information, including your curriculum vitae and the months and dates of any gaps in your professional activities since graduation from medical school. (See instructions.)

NAME: MELISSA NOTHNAGLE

Page 3 of 6

YES NO

14. Have you ever been enrolled in a residency program(s) where you were required to repeat a year of training? (See instructions).

Explanation attached: ☐Program Director's explanation requested: ☐

If you answered "yes" to question 14, a letter from your program director is required.

SECTION B: Read the instructions. Check either YES or NO to each question. Do not answer N/A. If you answer YES to any of these questions, you must provide details on the Limited License Supplement.

YES NO

15. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at any academic institution?
- 16-A. Have you ever been terminated by a medical school or postgraduate training program?
- 16-B. Have you ever been granted a leave of absence by a medical school or a postgraduate training program?
- 16-C. Have you ever voluntarily left, transferred or withdrawn from a medical school or postgraduate training program?

If you answered "yes" to 16-A,B or C, a letter from your medical school(s) or postgraduate training program(s) is required.

17. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or have you been accused of cheating and/or improper conduct during an examination?
18. Have you ever, for any reason, been denied a medical license, whether full, limited or temporary, or have you withdrawn an application for medical licensure?
19. Have you ever voluntarily surrendered a license to practice medicine or any healing art?

NAME: MELISSA NOTHNAGLE

Page 4 of 6

YES NO

20. 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).
21. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws or standards of practice by any governmental authority, health care facility, group practice, or professional medical society or association (international, national, state or local)? (See definition)...
22. 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?
23. Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?
24. Have you ever voluntarily relinquished medical staff membership?
25. Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?
26. Have you ever been charged with any criminal offense, other than a minor traffic offense?
27. 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?
28. 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?
29. 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?

NAME: MELISSA NOTHNAGLE

Page 6 of 6

SECTION C: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.This certifies that MELISSA NOTHNAGLE has been appointed
(Name of Applicant)to the position of ☐ Intern ☒ Resident ☐ Fellowin the specialty of Obstetrics & Gynecology as a PGY 2Department: OB/Gyn Subspecialty: _____at Boston Medical Center
(Name of Healthcare Facility)beginning 3 / 12 / 01 to anticipated completion of training: 4 / 6 / 01
(Month) (Day) (Year) (Month) (Day) (Year)**YES NO**Is the program accredited by the ACGME? ☒ ☐If no, is there an ACGME-approved training program in the applicant's specialty? ☐ ☐Designated Official's Signature: MAYINE KESSLERType or Print Name: MAYINE KESSLEROfficial Title: Director, Graduate Medical EducationDate: 2 / 1 / 01 Telephone Number: 617-414-5425



LIMITED LICENSE APPLICANT

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

MEDICAL EDUCATION VERIFICATION

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

Waiver for Release of Information

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

Applicant's Signature: [Signature] Date of Birth: _____

Print or Type Name: Nothnagle Melissa B Social Security No: _____
 (Last name) (First Name) (Middle Initial)

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

Name of Medical School: University of California San Francisco

Address: _____ City: San Francisco State or Province: CA

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

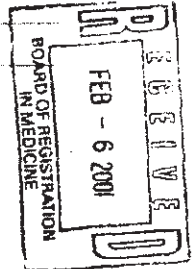
Premedical Education: Does your school have a premedical school education requirement? ☒ Yes ☐ No

If yes, indicate where the applicant completed premedical school

Applicant's Undergraduate School: Brown University

Undergraduate School Address: Providence RI

Continued on back



LIMITED LICENSE APPLICANT

Enrollment and Participation: Our records indicate that

Nothnagle Melissa B
(type or print the applicant's name) (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:		FROM	TO	FROM	TO
		09 / 04 / 95	06 / 15 / 96	07 / 01 / 98	06 / 13 / 99
		09 / 01 / 96	06 / 30 / 97		
		07 / 01 / 97	06 / 30 / 98		

The applicant attended 33-48 total weeks of continuing on-campus education, not less than 32 weeks in each academic year and

☒ was awarded a degree in Medicine on (month/day/year) 06 / 13 / 99

☐ was NOT awarded degree. Please explain reason(s) _____

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

YES NO

1. Did the applicant take any leaves of absence or breaks from his/her medical education?
2. Was the applicant ever placed on probation?
3. Was the applicant ever disciplined or under investigation?
4. Were any negative reports ever filed by instructors regarding the applicant?

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Maxine Papadakis

Print Name: Maxine Papadakis, MD

Title: Associate Dean

Date: 01 / 31 / 01 Telephone: (415) 476.1217

Post-graduate training

June 1999- June 2002
Memorial Hospital of Rhode Island
Dept of Family and Community Medicine, Brown University
Current PGY-2

Medical School

Sept 1995- May 1999
University of California, San Francisco
MD, May 1999

Undergraduate Education

Brown University, Providence, RI
Sept 1989- May 1993
BA, Psychology (minor in Visual Arts)

Rhode Island College, Providence, RI
Jan 1994- Dec 1994
Additional premedical courses

Studio Art Centers International, Florence, Italy
Jan 1992- May 1992
(semester abroad)

Employment

June 1996- Aug 1998
Dept. of Family Medicine, University of California San Francisco
Research Assistant
Literature review, data analysis, manuscript preparation on access to prenatal care for low income women

June 1993- Aug 1995
Dept. of Pediatrics, Brown University
Research Coordinator
Supervised data collection and analysis for studies of adolescent mothers and their children

Jun 1992- July 1995
Child Development Center, Dept. of Pediatrics, Brown University
Research Assistant
Collected and analyzed data on language development of infants with Down syndrome

Organizations

Rhode Island Academy of Family Practice
Advisory Board Member

Brown University Family Medicine Interest Group
Resident Coordinator

Maternal and Child Health Program Committee for Quality Improvement



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

Physician Registration Renewal Application

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

•Remit \$400.00 for renewal fee (non-refundable).

•Add late fee of \$25.00, if necessary.

•Return renewal application in GREEN envelope.

•Board of Medicine check with coupon in BLUE envelope.

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

1. Current Status: Active

Registration No. 213320

Renewal Date: 01/15/2003

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

☐ Active

☐ Retiring (see instructions)

☐ Inactive (see instructions)

☐ Do not wish to renew

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

A) Mailing/Business Address:

3. Melissa B Nothnagle

B) Home Address:

Home Phone:

Business Phone: (401) 729-2206

Please make corrections (print)

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

Mailing Address:

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Address: 111 Brewster St.

City/Town: Pawtucket State: RI

Zip: 02860 Country: US

Business Telephone: (401) 729-2760

Home Address:

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: () _____

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

4. a) Date of Birth:

b) Sex:

c) SS#:

F

5. a) Name of Medical School:

University of California School of Medicine, SF

b) Year Graduated: 1999 c) Degree: M.D.

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

Code(s) Hours per Week in Mass.

0

0

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

8. Drug License Numbers, if any:

a) Federal (DEA):

b) Massachusetts:

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

RI

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

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

Facility Code: 996/ (AP) 10 % Facility Code: / (AP) % Facility Code: / (AP) %

Facility Code: 998/ ✓ (AP) 90 % Facility Code: / (AP) % Facility Code: / (AP) %

If 999, print name(s):

LICENSE NUMBER: 213320

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit
Insurer's name. (Required): National Union Fire Ins Co Policy dates: From: 12/31/01 To: 12/31/02
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.
☐ Otherwise exempt Please explain exemption: _____
12. What is your principal work setting? (See Table 4) 2 1 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.
Principal work setting in MASS = 21, but only 10% time. 90% time practicing in RI, code = 45
13. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: A) inpatient care 0 hrs/wk B) outpatient care 4 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? 100 %

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

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

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

CME EXEMPTION: Check one: ☐ Inactive status ☒ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

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

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

Signature: _____

Date: 11 / 16 / 02.

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

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

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

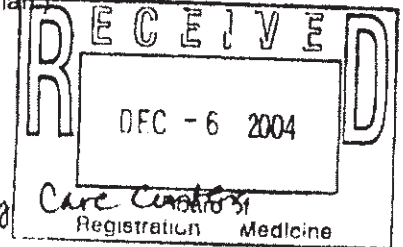


Massachusetts Board of Registration in Medicine Physician Profile

MELISSA B NOTHNAGLE MD**I. Physician Information**

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

License Status:	Active
License Issue Date:	02/13/2002
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	None-Reported <i>Family Care Center</i>
Business Address:	Memorial Hospital 111 Brewster Street PAWTUCKET, RI 02860
Phone:	(401) 729-2700 2236
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	Clinic Out of State Hospital

**II. Education & Training**

Medical School:	Univ. of California, San Francisco, School of Med.
Graduation Date:	1999
Post Graduate Training:	-- BROWN UNIVERSITY - FAMILY MEDICINE RESIDENCY

III. Specialty

Area of Specialty:	<i>Family Practice</i> ** No specialty-listed **
ABMS Board Certification:	Family Practice

IV. Honors and Awards

BROWN UNIVERSITY CHIEF RESIDENT IN FAMILY
MEDICINE, 2001-2002

Professional Publications

Nothnagle M, Marchi K, Egarter S, Braveman P. Risk factors for late or no prenatal care following Medicaid expansions in California. Maternal and Child Health Journal. 2001;4:251-259.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Should active management of the third stage of labor be routine? American Family Physician. 2003;15:2119-2120.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Does metformin improve clinical features of polycystic ovary syndrome? American Family Physician. 2003;68:2163-2164.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Should we prescribe vaginal estrogens for relief of atrophic vaginitis? American Family Physician. 2004;69:2111-2112.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Medical methods for first trimester abortion. American Family Physician. 2004;70:81-83.

Nothnagle, M. Dysmenorrhea. In Rakel RE, Essentials of Family Practice, 3rd edition. Saunders, Philadelphia, 2005 (in press).

V. Professional Publications

~~This physician has reported no publications.~~

see attached list

VI. Malpractice Information

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

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

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

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

VII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:

The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

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

B. Hospital Discipline:

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

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

C. Board Discipline:

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

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

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

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

Please read the Board of Registration in Medicine Disclaimer



Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle

License No.: 213320

CWC

PART A

1) Current Status: Active

Renewal Due Date: 12/18/2004

Birth Date:

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

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone: _____

☐ Check here to change this address

2c) BUSINESS ADDRESS

Memorial Hospital
111 Brewster Street
Pawtucket, RI 02860

Phone: (401)729-2236

☐ Check here to change this address

Please make corrections (print)

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (____) _____

Home address cannot be a Post Office Box

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (____) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401-729-2923

5) Specialties (See Renewal Instructions, page 4.)

Delete?

Additional specialties:

Family Practice

☐

☐

☐

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

List Certifying Board(s) below:

Board Name

ABMS or AOA

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Certificate/Subspecialty

Correct?

Delete?

Family Practice

☒

☐

Family Practice

☒

☐

☐

☐

☐

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☐

☐

☐

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☐

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Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle

License No.: 213320

PART A

1) Current Status: Active

Due Date: 12/16/2004

Birth Date: (

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

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone:

☐ Check here to change this address

2c) BUSINESS ADDRESS

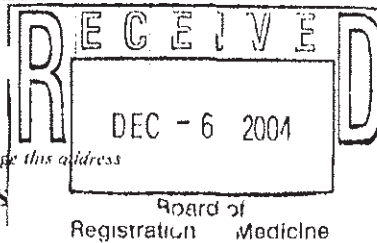
Memorial Hospital
111 Brewster Street
Pawtucket, RI 02860

Phone: (401) 729-2760

☒ Check here to change this address

3) E-mail Address: _____

4) Fax Number: 401 729 2923



Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: () _____

Home address cannot be a Post Office Box

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (401) 729-2236

Business address cannot be a Post Office Box

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Family Practice	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Certifications. (See Renewal Instructions, page 4.)	Delete?	Additional certifications:
Family Practice	<input type="checkbox"/>	
	<input type="checkbox"/>	
Critical Care Medicine	<input type="checkbox"/>	
	<input type="checkbox"/>	

License No.: 213320

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

Page 2 of 5

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle**

License No.: **213320**

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

Yes No

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

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

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

YES NO

14) CLAIMS MADE a) New: Has any medical malpractice claim been made against you during this time period, whether or not a lawsuit was filed on that claim? b) Pending: Are there any unresolved malpractice claims against you today, any claims that have not been finally settled or finally adjudicated?	
15) CLAIMS PAID Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?	
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any lawsuits, other than medical malpractice claims, been filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?	
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Are there any criminal charges pending against you today? c) Have any criminal offenses/charges against you been resolved during this time period?	
18) Have you been charged with or disciplined for any violation of laws, rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	
19) Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?	
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?	
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?	

22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
- b) If no, are you requesting a CME waiver?
- ☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. (See Renewal Instructions, page 8.)
- c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)
- CME EXEMPTION:** (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle

License No.: 213320

PHYSICIAN PROFILE

- ☐ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- ☒ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

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

Signature: 

Date: 11 / 10 / 04

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

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle

License No.: 213320

PART A

1) Current Status: Active

Due Date: 12/16/2004

Birth Date:

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

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ Check here to change this address

2b) HOME ADDRESS

Phone:

☐ Check here to change this address

2c) BUSINESS ADDRESS

Memorial Hospital
111 Brewster Street
Pawtucket, RI 02860

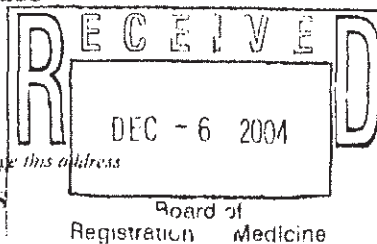
Phone: (401) 729-2260

☒ Check here to change this address

3) E-mail Address:

4) Fax Number:

401 729 2923



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

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

Home address cannot be a Post Office Box

Business Address: _____
City/Town: _____ State: _____
Zip: _____ Country: _____
Business Telephone: (401) 729-2236

Business address cannot be a Post Office Box

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Family Practice	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	
6) Current American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) Certifications. (See Renewal Instructions, page 4.)	Delete?	Additional certifications:
Family Practice	<input type="checkbox"/>	
	<input type="checkbox"/>	
Critical Care Medicine	<input type="checkbox"/>	
	<input type="checkbox"/>	

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle**

License No.: **213320**

<p><i>(See Renewal Instructions, page 4.)</i></p> <p>7) Drug License Numbers, if any:</p> <p>a) Massachusetts:</p> <p>b) Federal (DEA):</p> <p>c) Federal (DEA) XS:</p>	<p><i>Please make corrections as necessary</i></p> <p>8a) Other states where you are <u>now</u> licensed to practice (Abbr.)</p> <p style="text-align: center;"><u>RI</u></p> <p>8b) States where you were <u>previously</u> licensed (Abbr.)</p>
--	---

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

Principal Work Setting: ~~hospital~~

Change to: Educational Institution Hours per Week: 60

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 <i>(See Renewal Instructions, page 4.)</i>	Delete?	Staff Category		n Hours per Week
		Current	Change	
Clinic	<input checked="" type="checkbox"/>			
Out of State Hospital	<input type="checkbox"/>	<u>Active</u>		<u>40</u>
Franciscan Hospital for Children, Inc	<input checked="" type="checkbox"/>			
St. Elizabeth's Medical Ctr of Boston	<input checked="" type="checkbox"/>			
WEST ROXBURY VA HOSPITAL	<input checked="" type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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 4 hrs/wk Change to: 0 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)**

AON Risk Services of RI

Current Insurance Carrier: National Union Fire Ins Co of Pittsburgh Change to: (JUA)

Policy dates: From 7/1/04 To 7/1/05
(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

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle**

License No.: **213320**

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

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

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

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

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

22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
- b) If no, are you requesting a CME waiver?
- ☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. (See Renewal Instructions, page 8.)
- c) If you are exempt from CME requirements, check reason for exemption. (See Renewal Instructions, page 8.)
- CME EXEMPTION:** (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle**

License No.: **213320**


PHYSICIAN PROFILE

- ☐ I have reviewed my Physician Profile at profiles.massmedboard.org and confirm that the information is accurate.
- ☒ I have reviewed my Physician Profile and attached a copy of the Profile with corrections.
- ☐ My status is Inactive and I do not have a Physician Profile. (See *Renewal Instructions*, page 10.)

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c.19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L.c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c.112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. c.62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and 243 C.M.R. 3.00 et seq., and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

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

Signature: 

Date: **11 / 10 / 04**

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

Current Status: Active

License Expiration Date: 1/15/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: Memorial Hospital
111 Brewster Street
Pawtucket
Rhode Island - 02860
United States of America
(401) 729-2236

3) Email Address:

4) Fax Number: (401) 729-2923

5) Specialties
Family Medicine

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
Rhode Island

9) States where you were previously licensed
None Reported

10) Work Sites

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

WorkSite	Location
Out of State Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M D

License No.: 213320

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Acord Corporation Allied Professionals Ins	C 07/01/2012	07/01/2013	Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

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

18) Other Issues

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M D

License No.: 213320

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D

License No.: 213320

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

Compliance with Legal Responsibilities

Online profile:

☒ I have reviewed my Physician Profile and confirm that the information is accurate

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
 - 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
 - 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
 - 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
 - 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
 - 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
 - 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
 - 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
 - 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
 - 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 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.
 - 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- ☒ I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
- ☒ Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

PART A

1) Current Status: Active

Renewal Due Date: 12/18/2008

Birth Date:

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

Check only one: (See Renewal Instructions, page 3.)

☐ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

☐ Check here to change this address

2b) HOME ADDRESS

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (____) _____

Phone:

☐ Check here to change this address

2c) BUSINESS ADDRESS

Memorial Hospital
111 Brewster Street
Pawtucket, RI 02860

Phone: (401)729-2236

☐ Check here to change this address

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (____) _____

Home address cannot be a Post Office Box

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

3) E-mail Address: _____

4) Fax Number: 401-729-2923

5) Specialties (See Renewal Instructions, page 4.)

Delete?

List Additional Specialties:

Family Medicine

☐

☐

☐

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

List Certifying Board(s) below:

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Board Name

ABMS or AOA

Certificate/Subspecialty

Delete?

Family Medicine

ABMS

Family Medicine

☐

☐

☐

☐

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

(See Renewal Instructions, page 4.)

7) Drug License Numbers

Corrections:

a) Massachusetts: _____

b) Federal (DEA): _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

RI

9) States where you were previously licensed

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

List the names of all work sites in Massachusetts (See above and description on page 4.)	Location (City or Town)	State	Delete?
Out of State Hospital			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

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

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

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

☒ **Insurance Carrier (complete below)**

Current Insurance Carrier: Aon Risk Services

Change to: _____

Policy dates: From 7/01/08 To 7/01/09

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

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

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

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

☐ Otherwise exempt (Please explain): _____

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

Yes

No

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

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle, M.D.**

License No.: **213320**

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

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

YES NO

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

22) CME CERTIFICATION: a) Have you completed your CME requirements preceding your renewal date? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b) If no, are you requesting a CME waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No A CME waiver request form must be submitted at least 30 days prior to your license expiration date. c) If you are exempt from CME requirements, check reason for exemption. (<i>See Renewal Instructions, page 8.</i>) CME EXEMPTION: (check one) <input type="checkbox"/> Inactive Status <input type="checkbox"/> Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

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

Signature: _____

Date: 12/8/08

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

MELISSA B. NOTHNAGLE, MD

Department of Family Medicine
Memorial Hospital of Rhode Island
111 Brewster St.
Pawtucket, RI 02860
401-729-2236 (phone)
401-729-2923 (FAX)

EDUCATION

Brown University, Providence, RI	B.A., <i>magna cum laude</i> , Psychology	1989-1993
University of California San Francisco	M.D.	1995-1999
Maastricht University, Netherlands	Master of Health Professions Education, <i>in progress</i>	

POSTGRADUATE TRAINING

Family Medicine Residency

Brown Medical School/Memorial Hospital of Rhode Island	1999-2002
Pawtucket, Rhode Island	
Chief Resident	2001-2002

Faculty Leadership Development Fellowship

Department of Family Medicine	2004-2005
Brown Medical School/Memorial Hospital of Rhode Island	

POSTGRADUATE HONORS AND AWARDS

Faculty Preceptor of the Year, Family Medicine Residency, MHRI	2003
AAMC Early Career Women Faculty Development Seminar	2004

PROFESSIONAL LICENSES AND BOARD CERTIFICATION

Rhode Island Medical License	2002-present
Massachusetts Medical License	2002-present
American Board of Family Medicine	2002-2009

ACADEMIC APPOINTMENTS

Assistant Professor of Family Medicine, Brown Medical School	2004-present
Clinical Assistant Professor of Family Medicine, Brown Medical School	2002-2004
Clinical Instructor of Family Medicine, Brown Medical School	2001-2002

HOSPITAL APPOINTMENTS

Memorial Hospital of Rhode Island, Attending physician	2002-present
Full Family Medicine privileges including obstetrics	

OTHER APPOINTMENTS

Staff Physician, Planned Parenthood League of Massachusetts	2002-2003
Reviewer, <i>Journal of Health Care for the Poor and Underserved</i>	2002-present
Reviewer, <i>Annals of Family Medicine</i>	2004-present

Reviewer, <i>Family Medicine</i>	2004-present
Reviewer, <i>Medical Education</i>	2006-present

HOSPITAL COMMITTEES

Pediatric Review Committee	Memorial Hospital of Rhode Island	2002-2003
Graduate Medical Education Committee	Memorial Hospital of Rhode Island	2001-2, 04- present
Continuing Medical Education Committee	Memorial Hospital of Rhode Island	2004-2005
Credentials Committee	Memorial Hospital of Rhode Island	2004-present

UNIVERSITY COMMITTEES

Graduate Medical Education Committee, Brown Medical School	2003-present
Medical Education Working Group, Center of Excellence in Women's Health, Brown Medical School	2005-present
Curriculum Redesign Working Group on Assessment, Brown Medical School	2006-present
Program for Appropriate Treatment of Medical Students, Brown Medical School, Ombudsperson for Family Medicine	2007-present

MEMBERSHIP IN PROFESSIONAL SOCIETIES

American Academy of Family Physicians	1999-present
Rhode Island Academy of Family Physicians	2000-present
Advisory Board Member	2000-2002
Society of Teachers of Family Medicine	2002-present
Rhode Island Medical Society	2002-present
Association of Reproductive Health Professionals	2007-present

ORIGINAL PUBLICATIONS IN PEER-REVIEWED JOURNALS

Nothnagle M, Marchi K, Egerter S, Braveman P. Risk factors for late or no prenatal care following Medicaid expansions in California. *Maternal and Child Health Journal*. 2000;4:251-259.

Taylor JS, Kacmar JE, Nothnagle M, Lawrence RA. A systematic review of the literature associating breastfeeding with type 2 diabetes and gestational diabetes. *Journal of the American College of Nutrition*. 2005;24: 320-326.

Caro-Bruce E, Schoenfeld E, Nothnagle M, Taylor JS. Addressing gaps in abortion education: A sexual health elective created by medical students. *Medical Teacher*. 2006; 28:244-7.

Kacmar J, Taylor JS, Nothnagle M, Stumpff J. Breastfeeding practices of resident physicians in Rhode Island. *Medicine and Health Rhode Island*. 2006; 89:230-231.

Rubeor A, Nothnagle M, Taylor JS. Introducing osteopathic education within an allopathic residency. *Journal of the American Osteopathic Association*. 2007; in press.

Nothnagle M, Sicilia JM, Forman S, Fish J, Ellert W, Gebhard R, Kelly B, Pfenninger JL, Tuggy M, Rodney WM. Required procedural training in family medicine residency: A consensus statement. *Family Medicine*. 2007; in press.

Nothnagle M. Benefits of a learner-centered abortion curriculum for family medicine residents. *Journal of Family Planning and Reproductive Health*. 2007; in press.

OTHER PEER-REVIEWED PUBLICATIONS

Nothnagle M, Taylor JS. Cochrane for Clinicians: Should active management of the third stage of labor be routine? *American Family Physician*. 2003;15:2119-20.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Does metformin improve clinical features of polycystic ovary syndrome? *American Family Physician*. 2003;68:2163-4.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Vaginal estrogen preparations for relief of atrophic vaginitis. *American Family Physician*. 2004;69:2111-2.

Nothnagle M, Taylor JS. Cochrane for Clinicians: Medical methods for first-trimester abortion. *American Family Physician*. 2004;70:81-3.

Nothnagle M, Chandran R. Family medicine residency education: Staying on the cutting edge. *Medicine and Health Rhode Island*. 2006; 89:270-1.

BOOKS AND BOOK CHAPTERS

Nothnagle M. Dysmenorrhea. In Rakel RE, *Family Medicine: Fundamentals and Case Studies*, 3rd edition. Saunders, Philadelphia, 2005.

Nothnagle M. Vaginal bleeding in pregnancy. In Rakel RE, *Family Medicine: Fundamentals and Case Studies*, 3rd edition. Saunders, Philadelphia, 2005.

Brown J, **Nothnagle M**. Emergency Contraception. In Ferri FF, *Ferri's Clinical Advisor*. Elsevier-Mosby, Philadelphia; 2007, 2008.

Bialikiewicz A, **Nothnagle M**. Nabothian cysts. In McGarry KA, Tong IL, eds. *5 Minute Clinical Companion to Women's Health*. Philadelphia, PA: Lippincott, Williams, and Wilkins; 2007.

Bossenbroek K, **Nothnagle M**. Vulvar Mass. In McGarry KA, Tong IL, eds. *5 Minute Clinical Companion to Women's Health*. Philadelphia, PA: Lippincott, Williams, and Wilkins; 2007.

Pacheco C, **Nothnagle M**. Postpartum care. In McGarry KA, Tong IL, eds. *5 Minute Clinical Companion to Women's Health*. Philadelphia, PA: Lippincott, Williams, and Wilkins; 2007.

Wright E, **Nothnagle M**. Prenatal care. In McGarry KA, Tong IL, eds. *5 Minute Clinical Companion to Women's Health*. Philadelphia, PA: Lippincott, Williams, and Wilkins; 2007.

PUBLICATIONS SUBMITTED OR IN PREPARATION

Nothnagle M, Goodman S, Prine L. Benefits of comprehensive reproductive health education in family medicine. Submitted to Family Medicine.

Nothnagle M, Perron-Burdick M. Mixed methods evaluation of an intervention to improve osteoporosis screening in a residency practice. In preparation.

Boardman LA, **Nothnagle M**, Weitzen S, Steinauer J. Predictors of intention to provide abortion among U.S. Ob/Gyn residents. In preparation.

Taylor JS, Magee SR, **Nothnagle M**. *Mothers in Medicine: A Maternal-Child Health Survival Guide for Physicians*. A 15-chapter book following a maternal-child health timeline. Manuscript in progress.

ABSTRACTS (* = presenter)

International:

1. Taylor JS, **Nothnagle M**, Anthony D, Lavalley LK, Eaton CB. Development of a health disparities curriculum and evaluation tool. Society of Teachers of Family Medicine Annual Conference, Toronto, Ontario, Canada, May 2004.*
2. **Nothnagle M**, Harrison E. Controversial curricula: Introducing abortion care in a family medicine residency. Society of Teachers of Family Medicine Annual Conference, Toronto, Ontario, May 2004.*
3. **Nothnagle M**. Increasing access to safe abortion: Incorporating abortion care into family medicine training. Annual conference of Association for Medical Education in Europe, Annual Conference, Genoa, Italy, Sept 2006, poster.*

National:

1. Hopmann MR, **Nothnagle M**. Early vocabulary of normal and developmentally delayed infants: A longitudinal perspective. Society for Pediatric Research Annual Conference, Seattle, WA, May 1994, poster.*
2. Hopmann MR, **Nothnagle M**. Intentional communications by normal and developmentally delayed infants in structured and unstructured contexts. Society for Pediatric Research Annual Conference, Seattle, WA, May 1994, poster.*
3. Flanagan P, **Nothnagle M**, Andreozzi L, Garcia-Coll CT. Birth outcome to teen mothers as a function of maternal and familial sociodemographic characteristics. *Journal of Adolescent Health*. 1995;16(2):167. Society for Adolescent Medicine Annual Meeting, Vancouver, B.C., March 1995, poster.
4. Meyer EC, Flanagan P, Garcia-Coll CT, **Nothnagle M**, Ramos A, Kilis E, Kelly L, Oh W. Adolescent mothers of preterm infants report greater stress and lower maternal self-esteem than adult mothers. Society for Pediatric Research Annual Conference, San Diego, CA May 1995, poster.

5. Flanagan P, Garcia-Coll CT, **Nothnagle M**, Andreozzi L. Factors associated with maternal self-esteem and depression among adolescent mothers. *Pediatric Research, Program Issue APS-SPR*. 1996; 39(4) Suppl 2:16. Society for Pediatric Research Annual Conference, Washington, D.C. May 1996, poster.
6. James RA, Flanagan P, Jun S, **Nothnagle M**, Rubin LP. Infants of adolescents and need for neonatal special care. *Pediatric Research, Program Issue APS-SPR*. 1996; 39(4) Suppl 2:268. Society for Pediatric Research Annual Conference, Washington, D.C. May 1996, poster.
7. **Nothnagle M**, Taylor JS, Lavalley LK, Mallya G. Residents teaching students: One program's clerkship experience. Society of Teachers of Family Medicine Predoctoral Education Conference. Austin, TX, Jan 2003.*
8. Taylor JS, **Nothnagle M**, Lavalley LK, Monroe A, Goldman R, David SP, Eaton CB. Innovative curriculum on health disparities and cultural competency in primary care. Society of Teachers of Family Medicine Predoctoral Education Conference. Austin, TX, Jan 2003, poster.*
9. Caro-Bruce E, Schoenfeld E, **Nothnagle M**, Taylor JS. A collaborative preclinical sexual health elective created by medical students. the Society of Teachers of Family Medicine Predoctoral Education Conference. New Orleans, LA, Jan 2004.*
10. **Nothnagle M**. Do family medicine residents want to learn to provide abortions? National Abortion Federation Annual Conference. New Orleans, LA, Apr 2004, poster.*
11. Rubeor A, **Nothnagle M**, Chandran R. The integration of osteopathic education within allopathic residencies. Society of Teachers of Family Medicine Annual Conference. New Orleans, LA, Apr 2005.*
12. **Nothnagle M**, Perron-Burdick M. Practice-based intervention to improve osteoporosis screening in a residency clinic. Society of Teachers of Family Medicine Annual Conference, San Francisco, CA, Apr 2006.*
13. **Nothnagle M**, McGarry K. Creating an integrated osteoporosis curriculum for medical students through interdisciplinary collaboration. Society of Teachers of Family Medicine Annual Conference. Chicago, IL, Apr 2007.*
14. **Nothnagle M**, Goodman S, Kumar V, Leeman L. Balancing personal beliefs and professional responsibilities in resident education: Strategies for working with "opt-out" provisions. Society of Teachers of Family Medicine Annual Conference. Chicago, IL, Apr 2007.*
15. Taylor JS, Magee S, **Nothnagle M**. The maternal-child health of junior women faculty. Society of Teachers of Family Medicine Annual Conference. Chicago, IL, Apr 2007.*

Regional:

1. Dessie S, Magee S, **Nothnagle M**, Taylor JS. Exploration of the maternal-child health of women in academic medicine. Society of Teachers of Family Medicine Northeast Region Meeting, Pittsburgh, PA, 10/07.

INVITED PRESENTATIONS

National:

1. Mentoring workshop for women faculty. Preconference workshop at Society of Teachers of Family Medicine Annual conference, San Francisco, CA, Apr 2006.
2. Mifepristone training for primary care practitioners. University of Minnesota Family Medicine Residency Program, Minneapolis, MN, Sep 2007.

Regional:

1. Clinical Camp: IUD insertion training. Northeast Regional Society of Teachers of Family Medicine Conference, Danvers, MA, Oct 2006.
2. Why Family Medicine isn't just any old primary care. Roundtable discussion. Northeast Regional Society of Teachers of Family Medicine Conference, Danvers, MA, Oct 2006.

Local:

1. Update on hormonal contraception. Grand Rounds, Department of Family Medicine, Brown Medical School, Nov 2003.
2. Emergency contraception. Grand Rounds, Department of Family Medicine, Brown Medical School, Apr 2006.
3. Medical abortion: What pediatricians need to know. Hasbro Children's Hospital noon conference, Department of Pediatrics, Brown Medical School, May 2006.
4. Counseling patients about the levonorgestrel IUD. Providence Ambulatory Health Care, Inc. Aug 2007.

GRANTS

Integrated Osteoporosis Curriculum for Medical Students. Brown University/Women and Infants' Hospital National Center of Excellence in Women's Health Innovations in Women's Health Education Seed Grant, \$4,700, 10/05-10/06. Principal investigator.

Innovations in Medical Education: Service-learning curriculum in the Family Medicine clerkship. Brown Medical School, \$2,000, 10/03-12/04. Principal investigator.

Predoctoral training in primary care, Department of Health and Human Services Training Grant, \$388,000, 7/04-6/07. Co-author of grant proposal.

Women's Reproductive Health, Freedom, and Rights Curriculum. Private donor, 1/07-12/11. Associate Program Director, 10% FTE.

Innovations in Family Medicine Residency Education: Training for 21st Century Challenges. Health Resources Administration Training Grant. \$555,135, 7/07-6/10. Principal Investigator.

UNIVERSITY TEACHING ROLES

PREDOCTORAL TEACHING, Warren Alpert Medical School of Brown University

Assistant Director of Predoctoral Education, Department of Family Medicine, 2002-2003

Biomed 580: Family Medicine Clerkship, 2002-2003

Assisted Predoctoral Director in coordinating 6-week required clerkship curriculum (90 third- and fourth-year medical students per year).

Developed curricula and presented sessions on: Type 2 diabetes, culturally competent care of Latino patients, hormonal contraception, amenorrhea, first trimester abortion, smoking cessation, social and community context of health care, lesbian/gay/bisexual/transgender health, skin biopsy, health disparities in cancer. (10-12 hours per month)

Supervised one clerkship student per block in outpatient family medicine practice

Family Medicine Interest Group, Resident mentor, 2000-2002. Faculty advisor, 2003-2004.

Summer SEARCH program, Rhode Island Dept of Health/Brown Medical School.

Developed and presented half day introduction to clinical preceptorships (14 students), Jul 2003.

Mentored 1st year medical student in clinical practice and development and evaluation of an intervention to increase osteoporosis screening. Summer 2005 (8 weeks, full time).

Biomed GS0205: Sexual Health in the Community Context (elective) 2003

Faculty sponsor, course lecturer on Surgical Abortion (50 students).

Medical Students for Choice Faculty Advisor, 2003-present.

Present lectures sponsored by MSFC (30-40 first and second year students each):

First trimester surgical abortion (11/03), New developments in contraception (2/04, 4/05), Abortion myths (11/06)

Developed and presented skills workshop on manual vacuum aspiration for first trimester abortion (20 first- and second-year students) (4/04, 4/05, 4/07)

Biomed 583: Longitudinal Ambulatory Clerkship in Family Medicine, 2003-2004

Precepted fourth-year students one half day per week in my office practice 4/03-10/03, 3/04-9/04.

Biomed 571: Medical students' Outreach to Mothers-to-be (MOMS program), 2003-present

Presented small group workshops (10-20 students): Smoking cessation in pregnancy (10/03, 10/04), Postpartum contraception (3/06, 3/07, 3/08)

Biomed 363: Doctoring, Spring 2007

Created and presented half day module on Osteoporosis Screening and Fracture Prevention for 70 second-year medical students

Instructor for pelvic and breast exam training, assisted with curriculum development

Associate Director, Women's Reproductive Health, Rights, and Freedom Scholarly Concentration and Curriculum Development Program, 2007-present

FAMILY MEDICINE RESIDENCY TEACHING, Warren Alpert Medical School of Brown University

Assistant Residency Director, 2003-2007

Chair of Residency Curriculum Working Group

Outpatient curriculum coordinator

Recruiting coordinator

Didactic conference series director (2 per week)

Half day skills workshop director (6 per year):

Oversee skills training curriculum, organize workshops (35 residents each), teach small groups:

Gynecologic procedures (8/03, 4/06)

Type 2 Diabetes and Insulin therapy (3/04, 3/07)

Practice Management (3/04, 8/05, 8/06, 8/07)

Lower Extremity Orthopedics (4/05, 5/07)

Dermatologic procedures (5/05, 10/06)

Chronic Disease Management (10/05)

Obstetric Procedures (9/03, 9/04, 11/05, 10/06, 9/07)

Fracture management (3/06)

Sports medicine (5/06, 10/07)

Pediatric emergency procedures (4/07)

Associate Residency Director, 2007- present

Central leadership role in directing three-year Family Medicine program of 39 residents.

Responsible for development, implementation, and evaluation of residency curricula, leadership of residency education team and core faculty, resident performance evaluation and remediation, resident recruiting and selection, compliance with ACGME program requirements and duty hours.

Faculty Advisor to Family Medicine residents, 3-4 per year, 2002-present.

Preceptor, Family Medicine resident continuity clinic, 1-2 half days per week, 2002-present.

Attending physician, Family Medicine inpatient service, 6-7 weeks per year. 2002-present.

Attending physician, Labor and Delivery, 3-5 nights per month, 2002-present.

Abortion Care Curriculum, Gynecology rotation. 2003-present.

Developed, implemented and evaluated curriculum, precept half-day per week (13 residents per year)

Other Family Medicine Residency Teaching:

Maternal and Child Health Teaching Conference series (10 residents each):

Medical Abortion (5/03), Medical and Surgical Abortion (9/04), Options Counseling for Unplanned Pregnancy (10/03, 10/05), Postpartum contraception (8/06)

Family Medicine Residency Conference series (35 residents each):

Oral contraceptives: Managing patients on the pill (1/03), levonorgestrel IUD insertion training workshop (2/03), Emergency Contraception (8/04), Team dynamics and leadership for residents (8/05)

Mentor senior resident in leading bimonthly case review series (2005-2007)

Supervision of residents' Community-Oriented Primary Care projects (2005-present)

Osteoporosis screening and quality improvement- lecture for 15 students and residents (10/05)

Senior resident seminar: Job searches and interview skills (10/06)

Neonatal Resuscitation Program, instructor (9/06, 9/08)

FACULTY DEVELOPMENT

Faculty Development Series, Department of Family Medicine

Options counseling for unplanned pregnancy (9/03)

Practical skills for advising residents (9/04)

IUD insertion skills workshop (12/04, 8/07)

EXTERNAL TEACHING

ALSO (Advanced Life Support for Obstetrics) course instructor

University of Massachusetts Medical School, July 2007

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

PART A

1) Current Status: Active

Renewal Due Date: 12/18/2006

Birth Date:

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

Check only one: (See Renewal Instructions, page 3.)

☒ Active

☐ Retiring

☐ Inactive

☐ Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

Mailing Address: _____

City/Town: _____

State: _____

Zip: _____

Country: _____

☐ Check here to change this address

2b) HOME ADDRESS

Home Address: _____

City/Town: _____

State: _____

Zip: _____

Country: _____

Home Telephone: (____) _____

Phone:

☐ Check here to change this address

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

Memorial Hospital
111 Brewster Street
Pawtucket, RI 02860

Business Address: _____

City/Town: _____

State: _____

Zip: _____

Country: _____

Business Telephone: (____) _____

Phone: (401)729-2236

☐ Check here to change this address

Business address cannot be a Post Office Box

3) E-mail Address: _____

Correct your E-mail and Fax Number below:

4) Fax Number: 401-729-2923

5) Specialties (See Renewal Instructions, page 4.)

Delete?

List Additional Specialties:

Family Practice

☐

☐

☐

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

List Certifying Board(s) below:

Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.

Board Name ABMS or AOA

Certificate/Subspecialty

Delete?

Family Medicine

ABMS

Family Practice

☒

☐

☐

☐

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

<i>(See Renewal Instructions, page 4)</i> 7) Drug License Numbers Corrections:		<i>Please make corrections as necessary</i> 8) Other states where you are <u>now</u> licensed to practice <div style="text-align: center;"><u>RI</u></div>
a) Massachusetts: _____ b) Federal (DEA): _____ c) Federal (DEA) XS: _____	9) States where you were <u>previously</u> licensed _____	

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4)</i>	Location (City or Town)	State	Delete?
Out of State Hospital	<u>Pawtucket</u>	<u>RI</u>	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

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

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

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

☒ **Insurance Carrier** *(complete below)*

Current Insurance Carrier: Aon Risk Services

Change to: JUA (28012)

Policy dates: From 7/1/06 To 7/1/07

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

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

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

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

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

Yes No

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

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle, M.D.**

License No.: **213320**

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

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

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

22) CME CERTIFICATION:

- a) Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
- b) If no, are you requesting a CME waiver? ☐ Yes ☐ No

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

- 1) I certify that I have complied with my obligations to report abuse or neglect of children pursuant to G.L. c. 119, sec. 51A, and I understand the punishment for failure to comply.
- 2) I certify that I have complied with my obligations to report abuse or neglect of disabled persons pursuant to G.L. c. 19C, sec. 10, and I understand the punishment for failure to comply.
- 3) I certify that I have complied with my obligations to report abuse, neglect or financial exploitation of elderly persons pursuant to G.L. c. 19A, sec. 15, and I understand the punishment for failure to comply.
- 4) I certify that I have complied with my obligations to report the treatment of wounds, burns and other injuries pursuant to G.L. c. 112, sec. 12A.
- 5) I certify that I have complied with my obligations to report the treatment of victims of rape or sexual assault pursuant to G.L. c. 112, sec. 12A 1/2.
- 6) I certify that I have complied with my obligations to report a physician to the Board of Medicine, pursuant to G.L. c. 112, sec. 5F, when I have a reasonable basis to believe that person violated any provisions of G.L. c. 112, sec. 5 or any Board regulation.
- 7) I certify that I have complied with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, and I understand my obligations under G.L. c. 112, sec. 2.
- 8) I certify that I have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes, and I understand that, pursuant to G.L. c. 62C, sec. 49A, my license shall not be issued or renewed unless I make these certifications under penalties of perjury.
- 9) I certify that I have complied with my obligations related to the reporting of employees and contractors pursuant to G.L. 62E.
- 10) I certify that I have complied with my obligations related to the withholding and remitting of child support pursuant to G.L. c. 119A.
- 11) I certify that I have complied with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to G.L. c. 112 sec. 5 and the Patient Care Assessment Regulations, 243 C.M.R. 3.00 *et seq.* I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I certify that I have complied with my obligations to disclose my ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services pursuant to G.L. c. 112, sec. 12AA.

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

Signature: _____

Date: 11 / 18 / 06

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

Massachusetts Physician Renewal Application

Physician Name: **Melissa B Nothnagle, M.D.**

License No.: **213320**

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

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

☒ My current NPI is: **1023092806**

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

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

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

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

HIPAA TAXONOMY CODES

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

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

207000000X

Family Practice

Provider Taxonomy:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Provider Taxonomy:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US):

MASS

Country of Birth (if outside the US): _____

Gender: ☐ Male

☒ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: _____

Date: 11/18/06

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



Massachusetts Board of Registration in Medicine Physician Profile

Melissa B. Nothnagle, M.D.

I. Physician Information

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

License Status:	Active
License Issue Date:	2/13/2002
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Educational Institution
Business Address:	Memorial Hospital 111 Brewster Street Pawtucket, RI 02860
Phone:	(401) 729-2236
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	Out of State Hospital (Active)

II. Education & Training

Medical School:	Univ. of California, San Francisco, School of Med
Graduation Date:	1999
Post Graduate Training:	BROWN UNIVERSITY - FAMILY MEDICINE RESIDENCY

III. Specialty

Area of Specialty:	Family Practice
--------------------	-----------------

IV. Board Certifications

American Board of Medical Specialties (ABMS)

Board Name	General Certification	Subspecialty
Family Medicine	Family Practice	

V. **Honors and Awards**

BROWN UNIVERSITY CHIEF RESIDENT IN FAMILY
MEDICINE, 2001-2002

*Faculty Preceptor of the year, Brown Family Medicine
Residency, 2003*

VI. **Professional Publications**

*See attached publication
list*

MATERNAL AND CHILD HEALTH JOURNAL

2001; 251:258-9

AMERICAN FAMILY PHYSICIAN 2003; 16:2119-2120

AMERICAN FAMILY PHYSICIAN 2003; 68:2163-2164

AMERICAN FAMILY PHYSICIAN 2004; 69:2111-2112

AMERICAN FAMILY PHYSICIAN 2004; 70:81-85

ESSENTIAL SOF FAMILY PRACTICE, 3RD EDITION

SAUNDERS, PHILADELPHIA, 2005 (IN PRESS)

Journal of the American College of

*20
2163-4
Physician
Physician 2111-2
81-3*

VII. **Malpractice Information**

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

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

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

Dr. Nothnagle has not made a payment on a malpractice claim in Massachusetts in the past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:

The information in this section may not be comprehensive. The courts are now required by law to supply this information to the Board.

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

B. Hospital Discipline:

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

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

C. Board Discipline:

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

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

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

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

Please read the [Board of Registration in Medicine Disclaimer](#)



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- Kacmar J, Taylor JS, **Nothnagle M**, Stumpf J. Breastfeeding practices of resident physicians in Rhode Island. *Medicine and Health Rhode Island*. 2006; 89:230-231.
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- Nothnagle M**. Dysmenorrhea. In Rakel RE, *Family Medicine: Fundamentals and Case Studies*, 3rd edition. Saunders, Philadelphia, 2005.
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Pacheco C, **Nothnagle M**. Postpartum care. In McGarry KA, Tong IL, eds. 5 Minute Clinical Companion to Women's Health. Philadelphia, PA: Lippincott, Williams, and Wilkins; 2007.

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Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

Current Status: Active

License Expiration Date: 1/15/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

Memorial Hospital
111 Brewster Street
Pawtucket
Rhode Island - 02860
United States of America
(401) 729-2236

3) Email Address:

4) Fax Number: (401) 729-2923

5) Specialties
Family Medicine

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
Rhode Island

9) States where you were previously licensed
None Reported

10) Work Sites

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

WorkSite	Location
Camp Ramsbottom	Rehoboth
Out of State Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Promutual Insurance	07/01/2014	07/01/2015	Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

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

18) Other Issues

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M D

License No.: 213320

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

Compliance with Legal Responsibilities

Online profile:

☒ I have reviewed my Physician Profile and confirm that the information is accurate.

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
 - 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
 - 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
 - 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
 - 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
 - 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
 - 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
 - 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
 - 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
 - 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 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.
 - 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.
- ☒ I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
- ☒ Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

Current Status: Active

License Expiration Date: 1/15/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:

Memorial Hospital
111 Brewster Street
Pawtucket
Rhode Island - 02860
United States of America
(401) 729-2236

3) Email Address:

4) Fax Number: (401) 729-2923

5) Specialties
Family Medicine

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

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

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
Rhode Island

9) States where you were previously licensed
None Reported

10) Work Sites

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

WorkSite	Location
Out of State Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M.D.

License No.: 213320

11) Care of patients in Massachusetts

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

12) Medical Liability Insurance Information

Insurance Carrier
Lexington Ins Co

Policy Start Date
07/01/2010

Policy End Date
07/01/2011

Policy Type
Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

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- c) Are there any criminal charges pending against you today?
- d) Are any Application of Issuance of Process pending against you?

18) Other Issues

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

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Melissa B Nothnagle, M D

License No.: 213320

-
- 22) Have you completed all CME requirements (100 hours of CME of which 10 hours must be in risk management. Requirement: 40 hours credit in Category 1 and 60 hours in Category 2) for this renewal period? (If you are in an approved Residency/ Fellowship program, or if your are renewing your license for the first time, please answer Yes) Yes
- 23) Do you have a medical condition that interferes in any way or limits your ability to practice medicine?
- 24) Have you used any chemical substance(s) which in any way interferes with your ability to practice medicine?



Commonwealth of Massachusetts
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 - 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply
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 - 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number
 - 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician
 - 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me
- ☒ I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.
- ☒ Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.