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

Physician Registration Renewal Application

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

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

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

REDACTED COPY

1. Current Status: Active Registration No.: 156474 Renewal Date: 11/15/2001

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

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

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

Please make corrections (type or print)

Other Name(s): _____

3. A) Mailing/Business Address:
Pablo Rodriguez

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

B) Home Address:

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

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

Home Phone:

Business Phone:

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

4. a) Date of Birth: b) Sex: M
c) SS#:

5. a) Name of Medical School:
School of Medicine, State Univ. of N.Y. at Buffalo
b) Year Graduated: 1981 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass. 6 hours	
~~OBG~~	0	~~Obstetrics and~~ Gynecology
Gyn	0	

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

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

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

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

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

Facility Code: 100/✓ (AP) 0 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: 996/___ (AP) 100 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Rodriguez LICENSE NUMBER: 84774

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

Name of Insurer: Women & Infants Hospital Indemnity Alternatively, indicate as follows:

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

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

Please explain exemption: _____

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

13. A. What is your principal work setting? (See Table 4) 2 0

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

1) Average weekly hours involved in: a) outpatient care 6 hrs/wk b) inpatient care _____ hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

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

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

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

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

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

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

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

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

Signature: _____ Date: 5/30/01

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

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

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

Application #: 156474
Date of Issue: 5/5/98

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

RECEIVED MAY - 6

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)

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

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

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

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

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

Place of Birth: Fajardo | PR
City | State/Province/Territory | Country If not USA

Home Address: _____ _____
Number and Street

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

Business Address: 845 North main st
Number and Street

Providence | RI | 02904
City | State/Province/Territory | Zip (or postal) Code

Business Telephone: (401) 272-4050 ext. _____ Home Telephone: _____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

DATE: 5/6/98
INITIAL: RAK
FEE: $350.00 Check

APPLICANT'S NAME: Pablo Rodriguez

Pre-medical School

				From	To
Facility: University of Puerto Rico	Degree: BS			8/1/73	6/30/77
Street: Ponce de Leon Ave.	City: Rio PIEDRAS	State: PR			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Medical School

				From	To
Facility: State University of NY at Buffalo	Degree: MD			7/1/77	6/30/81
Street: Main Street # 3435	City: Buffalo	State: NY			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Date of medical school graduation: 1981

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.

				From	To
Facility: NASSAU County Med Center	Position: PGY 1,2,3,4			7/1/81	6/30/85
Street: 2201 Hempstead Tpke	City: East Meadow	State: NY			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			

APPLICANT'S NAME: Pablo Rodriguez

Hospital Affiliations and Employment

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

			From	To
Facility: Nassau County Medical Center	Position: PGY 1,2,3,4		7/1/81	6/30/85
Street: 2201 Hempstead Tpke	City: East Meadow	State: NY		
Facility: Women and Infants'	Position: Active		7/1/85	1/1/present
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: NY
2. Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
3. List Board Certification(s): American Board of Obstetrics & Gynecology
4. Have you attached an up-to-date copy of your curriculum vitae? ☐ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: PRACTICE EXPANSION
6. Name of Facility: Four Women Ob Gyn
7. Address: 152 E Mason St City: Attleboro MA 02703
8. Anticipated starting date in Massachusetts: 6/1/98

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

3/1/98
Date

Application #: 156474
Date of Issue: _____

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

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MAY - 6 1998

FULL LICENSE APPLICATION

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

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

Rodriguez Pablo
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: Fajardo PR
City State/Province/Territory Country if not USA

Home Address: _____ _____ _____
Number and Street

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

Business Address: 845 North main St
Number and Street

Providence RI 02904
City State/Province/Territory Zip (or postal) Code

Business Telephone: (401) 272-4050 ext. _____ Home Telephone: (_____

Preferred Mailing Address: ☐ Business Address ☒ Home Address

DATE: 5/6/98
INITIAL: RAK
FEE: $350.00 Check

APPLICANT'S NAME: Pablo Rodriguez

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				From	To
Facility: University of Puerto Rico	Degree: BS			8/1/73	6/30/77
Street: Ponce de Leon Ave	City: Rio Piedras	State: PR			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Medical School

				From	To
Facility: State University of NY at Buffalo	Degree: MD			7/1/77	6/30/81
Street: Main Street # 3435	City: Buffalo	State: NY			
Facility:	Degree:			/ /	/ /
Street:	City:	State:			

Date of medical school graduation: 1981

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.

				From	To
Facility: NASSAU County Med Center	Position: PGY 1,2,3,4			7/1/81	6/30/85
Street: 2201 Hempstead Tpke	City: East Meadow	State: NY			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			
Facility:	Position:			/ /	/ /
Street:	City:	State:			

APPLICANT'S NAME: Pablo Rodriguez

Hospital Affiliations and Employment

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

			From	To
Facility: Nassau County Medical Center	Position: PGY 1,2,3,4		7/1/81	6/30/85
Street: 2201 Hempstead Tpke	City: East Meadow	State: NY		
Facility: Women and Infants'	Position: Active		7/1/85	1/1/present
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: NY
2. Are you certified by the American Board of Medical Specialties? ☒ Yes ☐ No
3. List Board Certification(s): American Board of Obstetrics & Gynecology
4. Have you attached an up-to-date copy of your curriculum vitae? ☐ Yes ☐ No
5. Reason for requesting a Massachusetts medical license: PRACTICE Expansion
6. Name of Facility: Four Women Ob Gyn
7. Address: 152 E Mason St City: Attleboro MA 02703
8. Anticipated starting date in Massachusetts: 6/1/98

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

3/1/98
Date

Supplement Form

Name: Pablo Rodriguez Date: 03/1/98

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 matriculation 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 post-graduate training program?
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 matriculation 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 examination, 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 or temporary, or 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, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
8-B.			Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

Continued on page 2

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, denied, 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 this state or any 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 an inquiry by a professional liability insurance provider?

13. Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or other 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 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 been settled, adjudicated or otherwise resolved?

Continued on page 3

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

MALPRACTICE HISTORY

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

Waiver for Release of Information

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

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

Liability Carrier: MMJUA ✓
City: WARWICK State: RI
Policy Number: 22315

Liability Carrier: Women & Infants Indemnity Ltd ✓
City: Providence State: RI ✓
Policy Number: WIH 038

Liability Carrier: NORCAL ✓
City: Providence State: RI
Policy Number: 603073

Liability Carrier: Premier
City: Providence State: RI
Policy Number: ppl-003-122 (out of business) no claims

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

Signed: [signature] 3/5/18
Date

Print Name: Pablo Rodriguez

Commonwealth of Massachusetts--Board of Registration in Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (517) 727-3086

POSTGRADUATE TRAINING VERIFICATION

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

Name of Institution: NASSAU County Medical Center

Address of institution: 2201 (Street) Hempstead Tpke (City) East Meadow (State) NY 11554 (Zip)

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the Board or Registartion 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: Nassau County Medical Center

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

Enrollment and Participation: Our records indicate that Pablo Rodriguez (type or print applicant's name) participated in the following program:

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (ObG, internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM	TO:	Completed (YES/NO)
OB/GYN RESIDENCY	PGY 1,2,3,4	OBG	7 / 1 / 81	6 / 30 / 85	YES
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	
			/ /	/ /	

Continued on back

POSTGRADUATE VERIFICATION

APPLICANT'S NAME: Pablo Rodriguez

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 time of the applicant's participation, our postgraduate medical training was accredited by:

RRC ☐ Program was not accredited

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

Signature: [signature]

Print Name: Peter Hong, M. D.

Academic Title: Assistant Professor of Clinical Obstetrics and Gynecology-SUNY at Stony Brook

Telephone: (516) 572-6258 Date: 03 / 13 / 98

AFFIX INSTITUTIONAL SEAL HERE

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

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: _____ Social Security No: _____

Name of Medical School: State University of NY at Buffalo

Address: 40 Bio Education Bldg, 3435 Main St City: Buffalo State or Province: NY 14214-3013

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: _____

Undergraduate School Address: _____

Continued on back

Enrollment and Participation: Our records indicate that

Pablo Rodriguez

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

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	6/29/77	5/28/78	7/21/80	4/24/81
	5/15/78	5/14/79	/ /	/ /
	8/13/81	6/6/80	/ /	/ /

The applicant attended 4 years 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) 6/1/81

☐ 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?		

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: [signature]

Print Name: Dr. Dennis Nadler

Title: ESOC. Dean

Date: 3/18/98 Telephone: 710 824-2802

Supplement Form

Name: Pablo Rodriguez Date: 03/1/98

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 matriculation 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 post-graduate training program?
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 matriculation 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 examination, 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 or temporary, or 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, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?
8-B.			Has any disciplinary action (see definition) ever been taken against you by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?

Continued on page 2

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, denied, 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 this state or any 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 an inquiry by a professional liability insurance provider?

13. Have you ever been the subject of any suspension or probation proceedings instituted by Blue Cross and/or Blue Shield, Medicare, Medicaid, or any other medical reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross and Blue Shield, Medicare, Medicaid (any state), or other 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 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 been settled, adjudicated or otherwise resolved?

Continued on page 3

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

Physician Registration Renewal Application

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

- **Remit $400.00 for renewal fee (non-refundable).**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope.**

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

RECEIVED
2003 SEP 22 AM 11:09
BOARD OF REGISTRATION IN MEDICINE

1. Current Status: Active Registration No.: 156474 Renewal Date: 11/15/2005

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. Pablo Rodriguez

B) Home Address:

Home Phone:

Business Phone:

Please make corrections (print)

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

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

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

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

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

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

c) SS#:

5. a) Name of Medical School:
School of Medicine, State Univ. of N.Y. at Buffalo

b) Year Graduated: 1981 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
OBG	0	Obstetrics and Gynecology
GYN	6	Gynecology

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

8. Drug License Numbers,
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.)
NY

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

Facility Code: 100/✓ (AP) 0 % Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___% Facility Code: ___/___ (AP) ___%
If 999, print name(s): _____

PRINT YOUR LAST NAME: Rodriguez LICENSE NUMBER: 156474

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

Insurer's name. (Required) Women & Infants Indemnity Policy dates: From: 7 / 1 / 03 To: 6 / 30 / 04

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 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

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

1) Average weekly hours involved in: A) inpatient care _____ hrs/wk B) outpatient care 6 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 0 %

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

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

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

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

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

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

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

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

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

Signature: _____ Date: 8 / 31 / 03

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez **License No.:** 156474

PART A

1) Current Status: Active **Renewal Due Date:** 10/18/2005 **Birth Date:**

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

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

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

Please make corrections (print)

2a) MAILING ADDRESS

RECEIVED SEP 28 2005 BOARD OF REGISTRATION IN MEDICINE

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___) _____

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS

247 Roosevelt Avenue
Pawtucket, RI 02860

Phone: (401)727-4800

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401-726-1514

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez License No.: 156474

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

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

Principal Work Setting: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 6

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Sturdy Memorial Hospital, Inc.	☐	courtesy		0
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 6 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: Woman's Infant's Indemnity Change to: _____

Policy dates: From 6/30/05 To 6/30/06 *(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez License No.: 156474

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: Pablo Rodriguez License No.: 156474

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: 9/23/06

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez License No.: 156474

PART A

1) Current Status: Active **Renewal Due Date:** 10/18/2005 **Birth Date:**

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

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

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

Please make corrections (print)

2a) MAILING ADDRESS

☐ *Check here to change this address*

Mailing Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

RECEIVED SEP 28 2005 BOARD OF REGISTRATION IN MEDICINE

2b) HOME ADDRESS

Phone: (

☐ *Check here to change this address*

Home Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Home Telephone: (___) _____

Home address cannot be a Post Office Box

RECEIVED OCT 11 2005 BOARD OF REGISTRATION IN MEDICINE

2c) BUSINESS ADDRESS

247 Roosevelt Avenue
Pawtucket, RI 02860

Phone: (401)727-4800

☐ *Check here to change this address*

Business Address: _____

City/Town: _____ State: _____

Zip: _____ Country: _____

Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 401-726-1514

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez License No.: 156474

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

10/11/05 09:29:05 61 34

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

Principal Work Setting: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 6

10) List all current health care facilities where you are affiliated or have completed the credentialing process for the provision of patient care. (Supply the name of the health care facility from Reference Table 5 on Page 16 of the Instruction booklet). Next to each facility, write your staff category at that facility (Admitting, Active, Courtesy, Associate or Consulting), and the approximate number of hours of patient care that you provide at that facility. Include any affiliations with on-line prescribing services or companies. Please provide all information for additional facilities on a separate sheet, if necessary.

No Affiliations ☐ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
Sturdy Memorial Hospital, Inc.	☐	courtesy		0
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 6 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: Women Infant's Indemnity Change to: _____

Policy dates: From 6/30/05 To 6/30/06 *(required)*

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

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

Check one:

☐ Not involved with direct or indirect patient care in Massachusetts

☐ Government Employee Federal Tort Claims Act (FTCA)

☐ Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: **Pablo Rodriguez** License No.: **156474**

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: Pablo Rodriguez License No.: 156474

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: 9/23/06

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

Dr. Pablo Rodriguez 156474 License Number: 156474

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: 1376565531

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

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

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

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

HIPAA TAXONOMY CODES

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

	Taxonomy (Specialty) Code	Taxonomy Description (Print)
Primary Provider Taxonomy:	207VG0400X	Gynecology
Provider Taxonomy:		
Provider Taxonomy:		

NPI REQUIRED INFORMATION

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

Social Security Number:

State of Birth (if US): PR Country of Birth (if outside the US): _____

Gender: ☒ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: ☒ **I authorize** ☐ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

Please sign and date to confirm that all of the information on this form is true and accurate.

Signature: _____ Date: 3/23/07

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

MAR 2 3 2007

Dr. Pablo Rodriguez

03/20/2007

Dear Colleague:

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

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

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

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

Sincerely,

Martin C. Crane, M.D.
Board Chair

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. **License No.:** 156474

PART A

1) Current Status: Active **Renewal Due Date:** 10/18/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
247 Roosevelt Ave.
Pawtucket, RI 02860

☒ *Check here to change this address*

Please make corrections (print)

Mailing Address: 407 East Ave, Suite 150
City/Town: Pawtucket State: RI
Zip: 02860 Country: USA

2b) HOME ADDRESS

RECEIVED
OCT 15 2007
Board of Registration in Medicine

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
247 Roosevelt Avenue
Pawtucket, RI 02860

Phone: (401)727-4800

☒ *Check here to change this address*

Business Address: 407 East Ave, Suite 150
City/Town: Pawtucket State: RI
Zip: 02860 Country: USA
Business Telephone: (401) 727-4800

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 401-726-1514

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. License No.: 156474

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

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?**
Sturdy Memorial Hospital, Inc.	Attleboro	MA	☐
			☐
			☐
			☐
			☐

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

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

b) outpatient care 6 hrs/wk Change to: 0 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: Change to: _____

Policy dates: From 7/1/07 To 6/30/08

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

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

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. License No.: 156474

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: Pablo Rodriguez, M.D. License No.: 156474

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: 10/5/07

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. License No.: 156474

PART A

1) **Current Status:** Active **Renewal Due Date:** 10/18/2007 **Birth Date:**

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

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

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

2a) MAILING ADDRESS
247 Roosevelt Ave.
Pawtucket, RI 02860

☒ *Check here to change this address*

Please make corrections (print)

Mailing Address: 407 East Ave, Suite 150
City/Town: Pawtucket State: RI
Zip: 02860 Country: USA

2b) HOME ADDRESS

RECEIVED
OCT 15 2007
Board of Registration in Medicine

Phone:

☐ *Check here to change this address*

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

Home address cannot be a Post Office Box

2c) BUSINESS ADDRESS
247 Roosevelt Avenue
Pawtucket, RI 02860

RECEIVED
OCT 22 2007
Board of Registration in Medicine

Phone: (401)727-4800

☒ *Check here to change this address*

Business Address: 407 East Ave, Suite 150
City/Town: Pawtucket State: RI
Zip: 02860 Country: USA
Business Telephone: (401) 727-4800

Business address cannot be a Post Office Box

3) E-mail Address:

4) Fax Number: 401-726-1514

Correct your E-mail and Fax Number below:

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. License No.: 156474

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

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?
Sturdy Memorial Hospital, Inc.	Attleboro	MA	☐
			☐
			☐
			☐
			☐

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

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

b) outpatient care 6 hrs/wk Change to: 0 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: Change to: _____

Policy dates: From 7/1/07 To 6/30/08

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

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

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

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

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Pablo Rodriguez, M.D. **License No.:** 156474

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

ysician Name: Pablo Rodriguez, M.D. License No.: 156474

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: 10/5/07

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

CURRICULUM VITAE
PABLO RODRIGUEZ, MD

PERSONAL INFORMATION

Birth date	
Birthplace:	Fajardo, Puerto Rico
Citizenship:	USA
Social Security Number:	
Home Address:	
Business Address:	845 North Main St Providence, RI 02904
Business Telephone:	401-272-4050

EDUCATION

Undergraduate:	University of Puerto Rico Degree: B.S. Biology 1977 Cum Laude
Medical School:	State University of New York at Buffalo Degree: Medical Doctor 1981

POSTGRADUATE TRAINING

Residency:	Obstetrics & Gynecology Nassau County Medical Center East Meadow, NY 1981-85

POSTGRADUATE HONORS AND AWARDS

05/20/91	"Good Guy Award"by Women's Political Caucus, Providence, Rhode Island
08/31/91	"Most Outstanding Jibaro of RI" Puerto Rican Parade Annual Banquet
09/01/91	Grand Marshall- Fourth Annual Puerto Rican Parade of Rhode Island
09/27/91	Honorary Chair- First Annual Hispanic Heritage Ball, Providence, RI

CURRICULUM VITAE
PABLO RODRIGUEZ, MD

HONORS AND AWARDS

12/30/91	Aguila Dorada Award- Outstanding Health Professional of the Year, by Shoreline Newspaper
12/30/92	Aguila Dorada Award- Outstanding Health Professional of the Year, by Chamo's Productions
06/11/93	Roberto Clemente Award for Professional Achievement, by Hispanic Pro Education Committee of RI
6/94	1st. Community Service Award- Given by the American Medical Association, Young Physicians Section at the Annual Meeting in Chicago
09/94	Certificate of Appreciation for Invaluable Service and Dedication to Women's Reproductive Health, given by the American Medical Women Association
11/95	Lifetime Achievement Award given by Aspira of Puerto Rico at their 25th Year Anniversary Ball
06/96	"Community Hero Torchbearer" for the Olympic Torch Relay of the 1996 Olympic Games
10/30/96	Community Service Award given at Planned Parenthood of Rhode Island's Annual Meeting

PROFESSIONAL LICENSES AND BOARD CERTIFICATION

1982	Diplomate National Board of Medical Examiners
1985	Licensed in Rhode Island
1987	American Board of Obstetrics and Gynecology
1990	American Board of Laser Surgery and Medicine

ACADEMIC APPOINTMENTS

1984-85	Assistant Clinical Instructor in OBGYN State University of New York at Stony Brook

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ACADEMIC APPOINTMENTS

1986-1991	Clinical Instructor in ObGyn Brown University School of Medicine
1991- Present	Clinical Assistant Professor of Ob Gyn Brown University School of Medicine
11/96- Present	Lecturing Professor Universidad Nacional Pedro Henriquez Ureñas Santo Domingo, Dominican Republic

HOSPITAL APPOINTMENTS

11/95- Present	Associate Chief of Ob Gyn Women and Infants' Hospital 101 Dudley St, Providence, RI
7/87- Present	Active Staff Women and Infants' Hospital 101 Dudley St, Providence, RI

OTHER APPOINTMENTS

1995- Present	President- International Institute of Rhode Island
1991-93	President- Rhode Island Project AIDS
1993- Present	Trustee- Rhode Island Foundation
1994- Present	Director- Citizens Bank of Rhode Island
1994- Present	Vice Chair- Minority Investment Development Corporation, Providence, RI
1994- Present	Director- Urban Project of Rhode Island
1993- Present	Director, Chair Personnel Committee, Alan Guttmacher Institute, Washington DC
1992- Present	Chair- Minority Health Advisory Committee RI Department of Health
1990-93	HIV Program Advisory Committee RI Department of Health
1993- Present	Preventive Health Advisory Committee RI Department of Health
1991- Present	Year 2000 Health Objectives Task Force RI Department of Health
1994- Present	Judicial Nominating Commission State of Rhode Island

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PABLO RODRIGUEZ, MD

1992- Present	Governor's Hispanic Affairs Commission State of Rhode Island
1993- 94	Health care Reform Commission RI Department of Health

HOSPITAL COMMITTEES

11/90 - 11/93	Executive Committee at Women & Infants' Hospital
1992 - 94	Instruments and Technique Committee Women and Infants Hospital
5/91 -7/94	Chair - Operating Room Committee Women & Infants' Hospital
1985 - 90	Pharmacy and Therapeutics Committee Women & Infants' Hospital
1995 - Present	Executive Committee Ob Gyn Department Women & Infants' Hospital

MEMBERSHIP IN SOCIETIES

American Medical Association
American College of Obstetrics and Gynecology - Fellow
Association of Reproductive Health Professionals
Rhode Island Medical Society
American Association of Gynecologic Laparoscopists

INVITED PRESENTATIONS

03/03/87	Pre-Menstrual Syndrome Channel 36 Providence, Rhode Island
10/15/87	Sexually Transmitted Disease Update Hispanic Social Services Committee Providence, Rhode Island

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05/19/88	"Update on Human Papilloma Virus" University of Rhode Island Health Services
10/15/88	Risk Management Workshop on Pap Smears Association of Reproductive Health Professionals St Louis, Missouri
03/11/89	Teenage Pregnancy - Panel Discussion Channel 6 - Providence, RI
09/15/89	"Medical Consequences of Webster vs Reproductive Health Services", at Sarah Doyle Women's Center Brown, University, Providence, RI
10/28/89	"Medical Aspects of Substance Abuse" Substance Abuse Council of City of Providence Hispanic Peer Counselors Retreat
01/06/90	"Medical Aspects of Abortion" Rhode Island Caucus of Women Legislators Annual Retreat
03/24/90	"The Role of the Church in the AIDS Crisis" Conference for RI Black Religious Leaders
1990 - 94	Host of "Enfoque Latino" Weekly TV show on topics affecting the Hispanic Community
11/07/90	Access to Health Care Workshop presented at "Coming Together" 2nd Annual New England Hispanic Conference
12/10/90	"The Health of Minorities in America" guest appearance at Shades, Channel 36 Providence, RI
02/20/91	"Introduction to Norplant" RI Department of Health presentation to Title X Providence, RI

03/21/91	"Laparoscopic Adhesiolysis and Management of Distal Tubal Obstruction" presented at Update in Operative Laparoscopy, Women & Infants' Hospital Providence, RI
04/02/91	"Update on AIDS and the College Population" Presentation to the Administration of Rhode Island College, Bristol, RI
04/13/91	"Norplant Practicum" Training for Physicians, Women & Infants' Hospital, Providence, RI
04/23/91	"The Health of Minority Males in RI" presented at Shades - Channel 36 - RI Public TV
04/25/91	"The Bethesda System of Pap Smear Reporting" presented at Brown University Health Services, Providence, RI
04/30/91	"Priority Health Issues for Hispanic Males in RI" presented at Working Together: The Community's Agenda for Improving the Health of Minority Males in RI, sponsored by the RI Department of Health under HHS grant
05/91 - 08/92	Host of "Women's Health Hour" Weekly talk show on Women's Health Issues - WALE, Providence, RI
05/17/91	"Introduction to Norplant" presented at the 12 Th Annual Reproductive Health Review, JSI Research and Training Institute, Boston, Mass
05/18/91	"Norplant Practicum" - Training Session for Physicians held at Women & Infants' Hospital, Providence, RI
06/04/91	Keynote Speaker, "Upward Bound Program" Rhode Island College, Providence, RI

08/29/91	"Norplant Practicum for Family Residents", Memorial Hospital, Pawtucket, RI
09/19/91	"Norplant Practicum for Title X Providers", Marriott Hotel, Providence, RI
03/12/92	"Current and Future Directions in Contraception", presented at Reproductive Health Update 1992 URI College of Pharmacy, Newport, RI
03/28/92	"Contraceptive Alternatives in the 90's: Long Acting Implants" presented at RI Academy of Family physicians Annual Conference, Newport, Rhode Island
05/16/92	"AIDS Overview for 1992" Keynote Speaker, Project Aware Conference: HIV Issues '92, Fall River, Mass
05/16/92	"Controversies in the Management of HPV" presented at HPV Update, Conference for Title X providers, Providence, RI
06/19 - 06/22/92	"Laparoscopic Assisted Vaginal Hysterectomy Workshop" sponsored by Brown University Medical School, Providence, RI
01/16/93	"Sexuality and Contraception" presented at the Women and Infants/Lincoln School Anniversary Forum, Providence, RI
01/27/93	"Norplant Insertion Workshop" presented at the RI's American Academy of Family Practitioners Annual Meeting, Newport, RI
04/20/93	"Norplant Use in Clinical Practice" sponsored by Wyeth Ayerst Laboratories, Springfield, Mass
05/12/93	"Freedom of Access to Clinic Entrances Act of 1993" - Testimony before the Senate Committee on Labor and Human Resources

06/18 - 06/19/93	"Laparoscopic Assisted Vaginal Hysterectomy, Burch Procedure Workshop" Brown University, Providence,
09/14/93	"Norplant Use Complications and Management" sponsored by Wyeth Ayerst Labs, Boston, Mass
10/04/93	"Laparoscopy in the Diagnosis and Treatment of Endometriosis" sponsored by TAP Pharmaceuticals, presented at the Capital Grille, Providence, RI
10/23/93	"Medical Management of GYN Conditions" presented at Clinical Nursing Leadership in Women's Health '93, Sea Crest Resort, North Falmouth, Mass
10/25/93	"Long Term Contraception: Indications and Management of Complications" sponsored by Wyeth Ayerst Laboratories at the Sheraton Hotel, Leominster, Mass
05/25/94	"Norplant Update: Insertion & Removal Techniques" sponsored by Wyeth Ayerst Pharmaceuticals at the Poponessett Inn, New Seaburg, Mass
06/16/94	"Norplant Update: Insertion and Removal Techniques" sponsored by Wyeth Ayerst Pharmaceuticals at Carvey's, Manchester, Mass
10/14/94	"Contraceptive Technology: New Options" presented at the 1994 Cross Training in Women's Wellness Conference, Newport, RI
03/29/95	"Common Ground: Discussing the Issue of Abortion" presented at the monthly meeting of URI College Liberals Association

03/30/95	"The Health of Minorities in RI" guest on Shades, channel 36, RI Public TV
05/10/95	"What the Provider Faces" presented at Protecting Abortion Providers: Challenges and Opportunities meeting of National Pro Choice Foundations, New York City, NY
05/26/95	"Hispanic and Family Planning" presented at "Cultural Issues in Family Planning" sponsored by RI Department of Health Family Planning Program, Providence, RI
06/04/96	"Cultural Differences and Attitudes Towards Pregnancy and HIV" presented at Teenage Pregnancy Prevention Conference, Planned Parenthood of RI, Providence, RI
11/14/96	"Modern Management of Ectopic Pregnancy" presented at the Manuel Emilio Perdomo Memorial Lecture, Universidad Nacional Pedro Henriquez Ureñas, Santo Domingo, Dominican Republic