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

REDACTED COPY

Registration No.	Status	Fee	Renewal Date	Late Fee
77622	ACTIVE	$250.00	04/16/94	$25.00

Mailing Address:
PAUL A ISAACSON, M.D.

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

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

For Office Use Only
M.R. APR 19 1994
Pr.
Bk/D.E.

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):

3. Date of Birth: Sex: M
   Lic. Issue Date: 05/12/93 SS#:
   Telephone Number:
   Home Business
   (617)732-6937

4. Name of Medical School:
   Tufts University School of Medicine
   Year Graduated: 91 Degree: MD

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

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

Code	Hours per Week in Mass.
0	
0	

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

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

Corrections of Pre-Printed Information

Name: _____
Address (Home): _____
City/Town: _____
State: _____ Zip: _____
Country Code: _____ If 999 print Country: _____
Address (Business): _____
City/Town: _____
Country Code: _____ If 999 print Country: _____

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

Full Name of Medical School: _____

Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Code	Hours per Week in Mass.
___ ___ ___	
___ ___ ___	

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

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

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

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name: ISAACSON Registration Number: 77622

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

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

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

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am
(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS:____ (ii) OTHERWISE EXEMPT: ____
(State how otherwise exempt): ____

12. Current Health Care Facility Affiliations. Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).
Facility Code: 9 2 1 / ___ (AP) Facility Code: 1 6 8 / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)
Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)
If 999, print name(s): ____

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

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes X No____ (Check one)

14. a) What is your principal work setting? (See Table 5) 1 0

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

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

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

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

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

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

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

Signature: Paul Isaacson Date: 4/14/94

RECEIVED 1993

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

Fee — $300 to be submitted

Filed: 8-31 For Office Use Application # _____
By: PF
Form of Fee: 350 Certificate # 77622 Date of Issue 5/12/93

Please Print **SWORN STATEMENT** Date: January 31, 1993

Name Paul Allen Isaacson Address* _____
First Middle Last

Date of Birth _____

Place of Birth Detroit, Michigan Address valid from: (Dates) Present -

Name on Birth Certificate Paul Allen Isaacson Phone # DAY: 732-6987 Beeper 3703 HOME: _____

Pre-Medical Education

School Boston College

Years Attended 1982 - 1987

Medical Education

School Tufts University School of Medicine

Years Attended 1987 - 1991

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

Place	*Position*	*Dates*
Brigham and Women's Hospital	Resident	6/18/91 - Present

Is this your first license? Yes If applicable, please list all other states where you are or have been licensed:
- Have Limited Liscense in MA currently

Other names under which you have been licensed: _____

List Specialty Boards by which you are certified: _____

REASON APPLYING FOR A MASS. LICENSE: Wish to practice in Massaduesetts

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

AFFADAVIT OF APPLICANT:

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

Paul Isaacson MD Date: 1/31/92

(SIGNATURE OF APPLICANT)

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

(617) 727-3086

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

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

FORM E

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

I CERTIFY THAT Paul A. ISAACSON CREDITABLY
NAME OF APPLICANT

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

Boston College · Chestnut Hill, MA
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: TUFTS University School of Medicine
NAME OF MEDICAL SCHOOL

BOSTON, MA
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT Paul A. ISAACSON
NAME OF APPLICANT

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

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: TUFTS University School of Medicine
NAME OF MEDICAL SCHOOL

FORM E CONTINUED ON NEXT PAGE

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

(617) 727-3086

DINESH PATEL, M.D.
CHAIRMAN
ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

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

NAME OF APPLICANT: Paul A. ISAACSON MD

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

FROM:	Aug. 31,	1987		TO:	May 27,	1988		
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	Aug. 15,	1988		TO:	May 19,	1989		
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	July 5,	1989		TO:	June 15,	1990		
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:	July 2,	1990		TO:	April 19,	1991		
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:				TO:				
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	
FROM:				TO:				
	MONTH	DAY	YEAR		MONTH	DAY	YEAR	

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

ON May 12 19 91 .

Cristina S. Lewis

SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Cristina S. Lewis, Registrar

NAME AND TITLE (Please type or print)

DATE: APR 6 1993

SCHOOL SEAL

RECEIVED
APR 13 1993
BOARD OF REGISTRATION IN MEDICINE

Certification of Post-Graduate Training

FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, KENNETH J. RYAN MD. (Name), CHAIRMAN DEPT. of OB/GYN (Title)

hereby certify that Paul A. ISAACSON MD has served 1 3/4 year(s) of post-graduate training as a Resident (Position) in OBSTETRICS and Gynecology (Specialty) at Brigham and Women's Hospital (Hospital), BOSTON (City), MA (State).

This program is ✓ is not _____ approved by the ACGME or the RRC.

Dr. ISAACSON participated in this program from July (Month), 1991 (Year) to April (Month), 1993 (Year) and was issued _____ was not issued ✓ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

DR. ISAACSON is still in his residency training. I expect he will successfully complete this training at the end June 1995.

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

Signature of Director

4/5/93
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
Initial Limited License Application, Page 1 of 2

$ 50.00 Fee Payable to The Commonwealth of Massachusetts

91-5601-95

Important:
- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- Answer all non-optional questions (front and back of form) completely--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

Applicants please check one: *I am a 1) Graduate of a Medical School in the U.S., Canada or Puerto Rico* ✓ *2) Graduate of Foreign Medical School* ___
3) Graduate of Foreign Medical School applying under the Special Refugee Physician Program ___.

PLEASE NOTE: GRADUATES OF FOREIGN MEDICAL SCHOOLS MUST COMPLETE ADDITIONAL FORMS AS PART OF THE APPLICATION PROCESS.

SECTION A: Sworn Statement to be Completed by Applicant. (Complete Reverse Side Also)

1. a) Name (LAST:) ISAACSON (FIRST:) PAUL (M.I.:) A

1. b) Other Name(s): Have you ever been known under a different name or combination of names? Have you ever been licensed under a different name? If yes, please specify (and attach documentation): NO

1. c) Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If yes, please specify: NO

2. a) Name & address of Massachusetts Training Hospital: Brigham and Women's Hospital 75 Francis St. Boston, MA 02115

2. b) Local residence address & telephone : _____ Tel.#

3. Place of Birth: Detroit, Michigan

4. Date of Birth (MO/DA/YR): 5. Sex: MALE ✓ FEMALE ___ 6. Social Security No. (*Optional*). ___ ___ ___

7. a). Name of Premedical school(s): BOSTON College 7 b)Location: Chestnut Hill, MA
(City, State, Country)

8. a) Medical School Name: TUFTS U. School of Medicine 8 b) Location: (City,State,Country) BOSTON, MA
(See #3 under instructions)

8. c) Year Graduated: 1991 8. d) Degree: M.D. ✓ D.O. ___ Other (Specify) ___ MA 007

9. a) Previous post-graduate training: ___yes ✓no

b) Name of institution: _____

Address: _____

c) Name of Program: _____ Dates of training: _____

Continue answer on additional page if necessary

10. If you have had any one of the following, please circle which one and attach an explanation to this form: a) Leave of absence from medical school b) USMG more than four years of medical school education. c) FMG more than six years of medical education. Question 10 applies to me ___Yes ✓No. I have attached an explanation. Yes___ No___.

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Paul A. Isaacson has been appointed to the position of Intern ___, Resident x,
Fellow ___ in Program OB/GYN (Program) at Brigham & Women's Hospital (Institution) beginning 6/20/91
Anticipated completion Date of training 6/95. OBG 921
This program is accredited by the ACGME: Yes x No___
If no, we have an ACGME approved training program in the applicant's specialty: Yes___ No___
Designated Official's Signature: Hiroshi Tokubo 4/10/91
Type or Print Name and Title: Hiroshi Tokubo, Assistant Vice President, Medical Staff Services

(Applicant See reverse side - You must complete Section C)

FORM 11/89

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

11. Other States where you are now fully licensed to practice:
(Abbreviate): NONE

12. States where you previously were licensed to practice (This includes Residency Training Licenses)
(Abbreviate): NONE

13. If more than one year will have passed between the date of your graduation from medical school and the anticipated start date of your limited licensure in Massachusetts, please list your professional activities up to the present time, in chronological order. Please include employment experiences and training programs. Question 13 applies to me: Yes___ No✓ I have attached an explanation: Yes___ No___

14. Have you ever been enrolled in a residency training program(s) that you did not complete? Yes___ No✓ If yes, please attach an explanation detailing your reasons for not completing the program(s). In addition, you must provide a letter from the Program Director at the training program that you did not complete, certifying the circumstances under which you left the program. This letter must be sent directly to the Board by the Program Director. I have attached an explanation: Yes___ No___ Program Director's Certification has been requested: Yes___ No___

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?:		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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

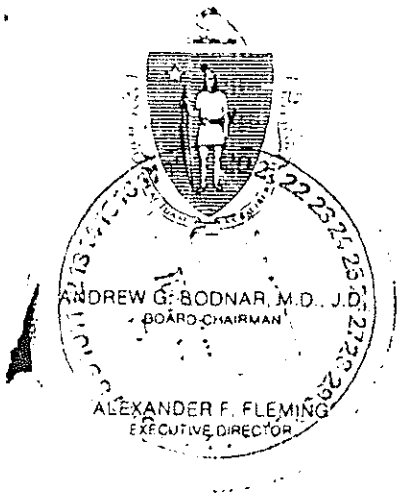
I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge, I meet the qualifications for limited licensure in Massachusetts.

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

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

Applicant's Signature: Paul Isaacs Date: 4/1/91

FORM 11/89



Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

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

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

I CERTIFY THAT Paul A. Isaacson (NAME OF APPLICANT) CREDITABLY

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

Boston College (UNDERGRADUATE EDUCATIONAL INSTITUTION) FROM 9/83 (DATES OF ATTENDANCE) TO 1/87 (DATES OF ATTENDANCE)

(SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)) FROM (DATES OF ATTENDANCE) TO (DATES OF ATTENDANCE)

for admission to: Tufts University School of Medicine (NAME OF MEDICAL SCHOOL)

I FURTHER CERTIFY THAT: Paul A Isaacson (NAME OF APPLICANT)

HAS COMPLETED AND ATTENDED FOR 4 (NUMBER) ACADEMIC YEARS OF INSTRUCTION, OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR.

Tufts University School of Medicine Boston, MA
NAME AND LOCATION OF MEDICAL SCHOOL

TO MEDICAL SCHOOL:

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

FROM:	MONTH	DAY	YEAR	TO:	MONTH	DAY	YEAR
	August	31,	1987		May	27,	1988
	August	15,	1988		May	19,	1989
	July	5,	1989		June	15,	1990
	July	2,	1990		May	12,	1991

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

ON May 12, 19 91 .

Janet S. Kerle, Registrar
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

Janet S. Kerle
NAME AND TITLE (Please type or print)

SCHOOL SEAL

DATE: April 9, 1991

Commonwealth of Massachusetts, Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Limited License Application, Page 1 of 2

___Renewal

Fifty Dollar Fee Payable to The Commonwealth of Massachusetts

Board Use Only:

Registration No.	Status	Fee	Date
		$50	

M.R. ____ ___/___/___
Pr. ____ ___/___/___
Bk. ____ ___/___/___
Ch. ____ ___/___/___
D.E. ____ ___/___/___
Fi. ENTERED MAR 18 1992

Important:

- *Read the accompanying instructions in their entirety before completing this form.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely*--**Even though the Board may have the information, it is not adequate to state that the Board already has the information.**
- *Sign the application at the bottom of page two.*
- **Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.**

SECTION A: **Sworn Statement to be Completed by Applicant.** (Complete Reverse Side Also)

1. Name (LAST:) ISAACSON (FIRST:) PAUL (M.I.:) A.
2. Mailing Address: _____
3. Name & Address of Training Hospital: Brigham and Women's Hospital 75 Francis St. Boston MA 02115
4. Medical School Name: Tufts University School of Medicine
5. Current Limited License Number: 91-5601-95
6. **To be completed by Program Director:**

I hereby certify that the above-named physician is in good standing in the Residency/Fellowship indicated. Has the physician been subject to past or pending disciplinary action in this program? ____Yes __x__No

Type or Print Name and Title Kenneth J. Ryan, M.D., Program Director & Chairman Dept OB/GYN

Signature of Program Director _____

SECTION B: TO BE COMPLETED AND SIGNED BY THE DESIGNATED OFFICIAL OF THE INSTITUTION AT WHICH THE APPLICANT HAS RECEIVED AN APPOINTMENT.

This certifies that Paul A. Isaacson, M.D. has been appointed to the position of Intern ____, Resident PGY-2

Fellow ____ in Program Obstetrics & Gynecology (Program) at Brigham and Women's Hospital (Institution) beginning 6/25/92 and

Anticipated completion date of training 6/24/95.

This program is accredited by the ACGME: Yes x **No** ____
If no, we have an ACGME approved training program in the applicant's specialty: Yes ___ **No** ___.

Designated Official's Signature: _____

Type or Print Name and Title: Marilyn McGowan, Director of Physician Services Date 3/12/92

(Applicant See reverse side - You must complete Section C)

FORM 1/91

SECTION C: Sworn Statement to be Completed by Applicant (Complete Reverse Side Also)

7. Other States where you are now fully licensed to practice:
(Abbreviate): NONE

Questions 8 through 14 not applicable.

Questions 15 through 24. Check either YES or NO (not N/A) to each question. Provide details on Form 15B, attached.

	Yes	No
15. Has any medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you been a defendant in any criminal proceeding other than a minor traffic offense?		
17. Are any formal disciplinary charges pending or has disciplinary action (as defined by Board regulations; See Attached From 15B) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason? Have you ever voluntarily surrendered a license to practice medicine or any healing art in lieu of disciplinary action (as defined by Board regulations; see attached Form 15B)?		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you had any organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (as defined by Board regulations; See Attached Form 15B) at an academic institution, since your matriculation in college?		
24. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or have you resigned from a medical staff in lieu of disciplinary action (as defined by Board regulations; See Attached Form 15B)?		

IF RESPONSES TO QUESTIONS 15-24 CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

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

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

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

I hereby certify under the penalties of perjury that all information on this form--front and back and ALL attached pages--is true to the best of my knowledge.

Applicant's Signature: Paul Isaacs Date: 2/28/92

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

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: Paul A. Isaacson Day time phone #: 617 732-6987 Beeper 3703

MAILING ADDRESS: _____ Business Address: Brigham and Women's Hospital
Dept. of OB/GYN
75 Francis St.
Boston, MA 02115

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

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

	YES	NO
1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)		
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?		
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?		
6. Have you ever failed a foreign licensing or certification examination?		
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?		
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?		
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?		
12. Have you ever, for any reason, lost American Specialty Board Certification?		
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____		
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?		
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
19. Have you ever held a license in Massachusetts or any other state or country? If yes, list other jurisdictions. MA - Limited License		
20. Have you ever been enrolled in a residency training program(s) that you did not complete?		

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

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

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

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

SIGNATURE: Paul Isaacson MD DATE: 2/2/93