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Board of Registration in Medicine

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Application #: _____
Date of Issue: ___/___/___

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

FULL LICENSE APPLICATION

Application Fee: Please enclose a check or money order in the amount of $600.00 made payable to the Commonwealth of Massachusetts. The application fee is non-refundable.

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

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

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

☑ M.D. ☐ D.O. ☐ Ph.D ☐ Other degree_____ ☐ Male ☑ Female

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: Fond du Lac WI
City State/Province/Territory Country if not USA

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: Same Telephone: _____
Number and Street

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

Business Address: _____ Telephone: _____
Number and Street

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

E-mail Address: _____ Fax number: _____

Are you applying for licensure through FCVS? (See instructions page 12) ☑ Yes ☐ No

*** The Board will use your Mailing Address for all correspondence**

PRINT NAME: Rebecca Posthuma

Pre-medical School

			From	To
Facility: University of Wisconsin	Degree: BS		7/1/98	5/1/03
Street: 333 East Campus Mall	City: Madison	State: WI		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: St. Louis University	Degree: MD		8/11/03	05/05/07
Street: 1402 S Grand Blvd	City: St. Louis	State: MO		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 5 / 19 / 2007
Month Day Year

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 in chronological order from medical school to the present. Include 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: Univ. of Minnesota	Position: PGY 1-4		6/1/07	6/3/11
Street: 515 Delaware St SE	City: Minneapolis	State: MN		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I	6-10-2005	☑ P	☐ F	1
USMLE Step II	ck 8-2006 / cs 12-2004	☑ P	☐ F	1
USMLE Step III	2-2009	☑ P	☐ F	1
NBME Part I		☐ P	☐ F	
NBME Part II		☐ P	☐ F	
NBME Part III		☐ P	☐ F	
FLEX Component 1		☐ P	☐ F	
FLEX Component 2		☐ P	☐ F	
FLEX Pre-1985		☐ P	☐ F	
NBOME Part I		☐ P	☐ F	
NBOME Part II		☐ P	☐ F	
NBOME Part III		☐ P	☐ F	
COMLEX Level 1		☐ P	☐ F	
COMLEX Level 2		☐ P	☐ F	
COMLEX Level 3		☐ P	☐ F	
COMVEX		☐ P	☐ F	
LMCC – Single		☐ P	☐ F	
LMCC – Part I		☐ P	☐ F	
LMCC – Part II		☐ P	☐ F	
State Board Exam	AZ (State of examination)	☐ P	☐ F	

PRINT NAME: Rebecca Posthuma

Hospital Affiliations and Employment

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

		From	To
Facility: Medicine Same Fellowship	Position: MD (ob/gyn)	8/1/11	11/1/11
Street: 333 7th Av, 2nd Floor	City: New York	State: NY	
Facility: St. Cloud Hospital	Position: ~~Res~~ MD (ob/gyn)	12/27/11	2/7/12
Street: 1406 6th Av N	City: St Cloud	State: MN	
Facility: Tuba City Regional Health Care Center	Position: MD (ob/gyn)	03/21/12	06/01/12
Street: 167 North Main Street	City: Tuba City	State: AZ	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

1. List other states (abbreviations) where you are currently or have ever had a full license: MN

2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☑ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☑ No

3. List Board Certification(s): Certification date: / /
   Certification date: / /

4. List your practice specialt(ies) ob/gyn

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

6. Reason for requesting a Massachusetts medical license: fellowship at ~~Massachusetts General Hospital~~

7. Name of Facility: Massachusetts General Hospital
   Address: 55 Fruit Street City: Boston

8. Anticipated starting date in Massachusetts: 7 / 1 / 12

Under the penalties of perjury, I declare that I have examined this full 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 a full 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 of Applicant

1 / 5 / 11
Month Day Year

(Continued on page5)

SUPPLEMENT FORM

PRINT NAME: Rebecca Posthuma DATE: 1/6/12

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

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate 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 enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: _____ Date: 1/6/12

		YES	NO
9-A.	Have you ever voluntarily relinquished any medical staff membership?		
9-B.	Has your medical staff membership, medical privileges or medical staff status at any hospital been limited, suspended, revoked, not renewed or subject to probationary conditions or has processing toward any of those ends been instituted or recommended by a medical staff committee or governing board?		
9-C.	Have you ever been denied medical staff membership, or advancement in medical staff status, or has such denial been recommended by a standing medical staff committee or governing body?		
9-D.	Have you ever, for any reason, withdrawn an application for hospital privileges or appointment?		
10.	Have you ever been charged with any criminal offense, other than a minor traffic offense?		
11.	Has your privilege to possess, dispense or prescribe controlled substances ever been suspended revoked, denied, restricted or surrendered, or have you ever been called before or warned by any state or other jurisdiction including a federal agency regarding such privileges?		
12.	Has any professional liability insurance provider ever restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage or have you ever voluntarily restricted, limited or terminated your insurance coverage in response to any inquiry by a professional liability insurance provider?		
13.	Have you ever been the subject of any suspension or probation proceedings instituted Blue Cross or Blue Shield, Medicare, Medicaid, or any other medical Reimbursement plan; or have you ever been restricted from receiving payments from any Blue Cross or Blue Shield, Medicare, Medicaid (any state), or third party programs?		
14.	Have you ever had an application for membership as a participating provider rejected by any HMO/PPO/IPA or other prepaid health care plan or your contract as a participating provider terminated by any HMO/PPO/IPA or other prepaid plan?		
15-A.	In the past ten (10) years, has any medical malpractice claim been made against you, whether or not a lawsuit was filed in relation to the claim or has such a suit been settled, adjudicated or otherwise resolved?		
15-B.	In the past ten (10) years, has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you or has such a suit been settled; adjudicated or otherwise resolved?		

Applicant's Signature: _____ **Date:** 1/6/12

Revised: 12.01.10

Board of Registration in Medicine
200 Harvard Mill Square, Suite 330 - Wakefield, MA 01880
Telephone: (781) 876-8210 Fax: (781) 876-8383 www.massmedboard.org

POSTGRADUATE TRAINING VERIFICATION

APPLICANT'S AUTHORIZATION: I authorize the release of information from my postgraduate training program listed below, as requested by the Massachusetts Board of Registration in Medicine.

Applicant's Signature: _____ Date: 1-6-2012

Print or Type Name: Rebecca Posthuma

Name of Institution: University of Minnesota

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: University of Minnesota

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

Enrollment and Participation: Our records indicate that Rebecca Posthuma (Print applicant's name) participated in the following program:

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	PGY1	OBGYN	6/11/2007	6/8/2008	Yes	ACGME
Residency	PGY2	OB/GYN	6/9/2008	6/7/2009	Yes	ACGME
Residency	PGY3	OBGYN	6/8/2009	6/6/2010	Yes	ACGME
Residency	PGY4	OBGYN	6/7/2010	6/3/2011	Yes	ACGME

(Continued on page 2)

APPLICANT'S NAME: Rebecca Posthuma

POSTGRADUATE VERIFICATION FORM PAGE - 2

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

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE
(If the institution does not have a seal, this form must be notarized by a notary public).

Program Director's Signature: _____

Print Name: Phillip N. Rauk, MD

Academic Title: Program Director

Telephone: (612) 626-6628 Today's Date: 01/09/2012

PLEASE RETURN THIS COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPED WITH YOUR SIGNATURE ACROSS THE SEAL OF THE ENVELOPE.

Seal Verified

DATE: 02/14/12

INITIALS: WS

REBECCA POSTHUMA, MD

TRAINING

Residency in Obstetrics, Gynecology and Women's Health — 6/2007 – 6/2011
University of Minnesota, Minneapolis, MN

EDUCATION

M.D. — 8/2003 – 5/2007
St. Louis University School of Medicine, St. Louis, MO

B.S. Biochemistry — 8/1998 – 5/2003
University of Wisconsin, Madison, WI

EXPERIENCE

Médecins Sans Frontières / Doctors Without Borders — 8/2011 – 11/2011
South Sudan

Worked as sole Obstetrician Gynecologist in the only secondary care hospital in the state. Responsibilities included management of Obstetric emergencies, complicated vaginal deliveries, breech vaginal deliveries, operative vaginal deliveries, exploratory laparotomy for gynecologic or obstetric complications, tropical disease care in pregnancy, management of national and expatriate midwives, training of national health care workers.

Health Partners Central Minnesota Clinics — 12/2011 – 2/2012
Sartell, MN

Rural private practice in Obstetrics and Gynecology as a locum tenens physician with high outpatient clinic volume. Served as principal referral center for numerous primary care providers.

Tuba City Regional Health Care Center — 3/2012 – 6/2012
Tuba City, AZ

Worked on the country's largest Navajo Reservation with Indian Health Services providing gynecologic care, both medical and surgical, and managing complicated obstetric issues in a high-risk, underserved population.

REBECCA POSTHUMA, MD

RESEARCH + PUBLICATIONS

Ghebre R, **Posthuma R**, Vogel RI, Geller MA, Carson LF. Effect of age and comorbidity on the treatment and survival of older patients with vulvar cancer. Gynecol Oncol. 2011 Jun 1;121 (3):595-9. Epub 2011 Mar 12. — 6/2011

Posthuma R, Ghebre R, Vogel RI. Vulvar cancer in the elderly: patterns and predictors of survival. Poster, Resident and Fellow Research Day, University of Minnesota. — 5/2010

Posthuma R, Blaskiewicz R. Fetal growth in women with concomitant diabetes and hypertension. Presentation and manuscript of original research, Alpha Omega Alpha Honor Society Research Symposium, St. Louis University. — 12/2006

Rancour DM, Park S, Bednarek SY. The plant UBX-domain containing (PUX) protein family regulates the function of *Arabidopsis* CDC48, a conserved essential AAA-ATPase. Poster, International Arabidopsis Research Meeting, University of Wisconsin. — 2/2005

PROFESSIONAL ORGANIZATIONS

American College of Obstetricians and Gynecologists

Médecins Sans Frontières Association

LANGUAGES

English

Spanish

PRESENETATIONS

Practicing Obstetrics in South Sudan, Grand Rounds, Regions Hospital 2/2012

Pelvic Pain, Chief Lecture, University of Minnesota, 4/2010

Choriocarcinoma, Grand Rounds, Regions Hospital, 1/2010

Pancreatitis in Pregnancy, Grand Rounds, Methodist Hospital, 11/2009

Cervical Ectopic, Morbidity and Mortality Conference, University of Minnesota, 9/2009

Review of Endometriosis and Adenomyosis, Resident Didactics, University of Minnesota, 4/2009

Hyperemesis Gravidarum, Grand Rounds, Regions Hospital, 2/2009

Review of Ectopic Pregnancy, Resident Didactics, University of Minnesota, 2/2009

Acute Intra-abdominal Hemorrhage, Morbidity and Mortality Conference, University of Minnesota Medical Center, 1/2009

A History of Intrauterine Devices and their Complications, Grand Rounds, Regions Hospital, 11/2007

REBECCA POSTHUMA, MD

VOLUNTEERISM + COMMUNITY

International Experience

Ecuador	Rotation in tropical medicine with Child Family Health International to study tropical medicine and international health issues	6/2004
Honduras	Mercy Ships charity hospital working as a Spanish interpreter for American and European physicians	6/2003
Nicaragua	Trekked into jungle to hold large scale health care clinics, served as Spanish interpreter	7/2002
Colombia	Humanitarian work for six months including community development, health and sanitation efforts, relief for displaced child and adult victims of civil violence, elementary education for children not otherwise able to afford schooling	6/2000

La Clínica (8/2003 – 5/2007)

Medical Student Director, trained and coordinated volunteer medical students at a not for profit clinic, developed orientation program and training material for volunteers and Spanish classes, directed fund raising, facilitated interest group meetings to raise cultural awareness, interpreted for patient and physician during office visits and at community health fairs.

American Medical Student Association (8/2003 – 5/2007)

Global Health Representative for Saint Louis University; orchestrated Global AIDS Awareness Week with speakers and activism events; recipient of Global Health scholarship; guest speaker at forum on international volunteer opportunities.

South Madison Health and Family Center (1/2000 – 5/2003)

Volunteered for three years as a Spanish interpreter in Madison, WI at a community health center working with doctors and midwives.

LICENSURE

Minnesota Board of Medical Practice License #54557

Personal and professional references available upon request

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Rebecca L Posthuma, M.D. **License No.:** 250786

Current Status: Active **License Expiration Date:** 11/27/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
55 Fruit Street
Yawkey 4E
Boston
Massachusetts - 02114
United States of America
(612) 726-7637

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology
Urogynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
Minnesota

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

WorkSite	Location
Massachusetts General Hospital	

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 25 hrs/wk
b) outpatient care 25 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	07/01/2012	06/30/2015	Occurrence Policy

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

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

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

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

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

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

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**