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FEB 04 2009
Board of Registration in Medicine

Application #: 235025
Date of Issue: ___/___/___

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

DAYANANDA	ILA	DATRI	
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: West Lafayette (City) IN (State/Province/Territory) _____ (Country if not USA)

*Mailing Address: _____ (Number and Street) Telephone: _____

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

Home Address: — Same as Mailing Address — (Number and Street) Telephone: _____

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

Business Address: 330 Brookline Ave kirstein 317 (Number and Street) Telephone: 617 667 2285

Boston (City) MA (State/Province/Territory) 02215 (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**

#293
600.00
2/7

PRINT NAME: ILA DAYANANDA

Pre-medical School

			From	To
Facility: PURDUE UNIVERSITY	Degree: B.S.		05/15/1995	05/08/1999
Street: Northwestern Ave	City: West Lafayette	State: IN		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: Northwestern University Medical School - Feinberg School of Medicine	Degree: MD		8/30/1999	5/21/2004
Street: 303 Chicago Avenue	City: Chicago	State: IL		
Facility: Northwestern University	Degree: MPH		8/24/1999	5/20/2004
Street: 303 Chicago Avenue	City: Chicago	State: IL		

Combined MD-MPH program

Date of medical school graduation: May / 21 / 2004
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.

Please see Supplement Question #2

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.

I have attached answer.

			From	To
Facility: Beth Israel Deaconess Medical Center	Position: PGY1-4		6/21/2004	6/20/2008
Street: 330 Brookline Ave	City: Boston	State: MA		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

PRINT NAME: ILA DAYANANDA

Pre-medical School

			From	To
Facility: PURDUE UNIVERSITY	Degree: B.S.		05/15/1995	05/08/1999
Street: Northwestern Ave	City: West Lafayette	State: IN		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

Combined MD-MPH program

			From	To
Facility: Northwestern University Medical School - Feinberg School of Medicine	Degree: MD		8/24/1999	5/21/2004
Street: 303 Chicago Avenue	City: Chicago	State: IL		
Facility: Northwestern University	Degree: MPH		8/24/1999	5/20/2004
Street: 303 Chicago Avenue	City: Chicago	State: IL		

Date of medical school graduation: May / 21 / 2004 (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.

↓ Please see Supplement Question #2

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I have attached answer.

				From	To
Facility: Beth Israel Deaconess Medical Center	Position: PGY1-4			6/14/2004	6/20/2008
Street: 330 Brookline Ave	City: Boston	State: MA			
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)	Failed (F)	Number of attempts
USMLE Step I	6/22/2001	☒ P	☐ F	1
USMLE Step II	9/16/2004	☒ P	☐ F	2
USMLE Step III	6/01/2006	☒ 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	(State of examination)	☐ P	☐ F	

PRINT NAME: ILA DAYANANDA

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: Beth Israel Deaconess Medical Center	Position: OB/GYN Resident	04/14/04	06/20/08
Street: 330 Brookline Avenue	City: Boston	State: MA	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	
Facility:	Position:	/ /	/ /
Street:	City:	State:	

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

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): ϕ Certification date: / /

   Certification date: / /

4. List your practice specialt(ies) Obstetrics & Gynecology

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

6. Reason for requesting a Massachusetts medical license: I will be graduating from residency and plan to start a Family Planning Fellowship at Brigham & Womens' Hospital Boston MA in Summer 2008.

7. Name of Facility: Brigham & Women's Hospital

   Address: Francis St City: Boston, MA

8. Anticipated starting date in Massachusetts: 07/01/08

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.

Ila Dayananda
Signature of Applicant

02 / 02 / 2008
Month Day Year

(Continued on page 5)

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 full license application to be complete, 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. You must notify the Board once you have received your NPI Number. 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). You must notify the Board once you have received your NPI Number.
Option 4: Authorize the Board of Registration in Medicine to apply for an NPI on your behalf.

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

☒ My current NPI is: 1 5 5 8 5 4 8 4 4 6

☐ I have personally applied for an NPI.

☐ 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.

HIPAA TAXONOMY CODES

Please provide the HIPAA taxonomy (specialty) codes. (Taxotomy codes are on following page of this license application and page 12 of Full License Application Instructions). 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:	2 0 7 V 0 0 0 0 0 X	Obstetrics & 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): IN 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 to any authorized hospital, health plan or health organization.

Signature of Applicant

02/02/2008
Date

CURRICULUM VITAE for HARVARD MEDICAL APPOINTMENT

General Information:

Date Prepared: January 25, 2008

Name: ILA DAYANANDA

Home Address:

Phone:

Email:

Place of Birth: West Lafayette, IN; USA

Education:

Year	Degree	Institution
6/14/2004- Projected End 6/20/2008 OB/GYN Residency Program		Harvard-Beth Israel Deaconess Medical Center
8/24/1999-5/ 21/2004	MD	Northwestern University Feinberg School of Medicine
8/24/1999- May 20, 2004	MPH	Northwestern University
5/15/1995-5/08/1999	BS Honors	Purdue University

Committee Assignments and Administration Responsibilities:

NORTHWESTERN UNIVERSITY MEDICAL SCHOOL

2001 In Vivo 2001 "Austin Bowels"
Wrote and Directed the Thematic Script "Austin Bowels" - 1 hour long. In Vivo is a 2-3 hour variety production centered on
medical humor, and is written, directed, and performed by Northwestern University. The proceeds from the show are donated
to a local charity chosen by the student producers.

2000-01 Medical Students for Reproductive Health and Choice – President
Helped to organize and host regional conference held at Northwestern University (2001)
Aim to increase awareness of women's health issues through monthly speakers/events and "contraception fair"

1999 Medical Student Senate (1999)

Elected Senator - Representative for Till College
Academic Affairs Committee
Personal accomplishment: Addition of *White Coat Ceremony* Tradition for Incoming MS1 Class, Fall 2000

1999 Patient Perspectives (1999): a program that pairs medical students with patients for a
Semester- participated at the Rehabilitation Institute of Chicago - Pediatrics

PURDUE UNIVERSITY

1997-99 Women in Science Program - Undergraduate Leadership Team (1997-99)
planned monthly speakers and programs to address the career opportunities and needs of women in science,
matched freshmen women in science with upper class mentors, worked to secure future of program

1995-98 Biology Club - President (1997-98); Secretary (1996-97)
Worked to plan monthly programs and activities, increase student-faculty interaction and present the variety of opportunities
in the biological sciences
Started the "Rent – A – Clone" program in which faculty members take a undergraduate student into their lab for an afternoon
in exchange for the students help; gives the student exposure to the laboratory environment

1995-1999 Purdue Science Student Council (1995-1999)
Merchandise Co-Chairperson (1996)- in charge of fundraising and sales
New Student Orientation Chairperson (1997, 1998)

Civic and Community Service:

NORTHWESTERN MEDICAL SCHOOL

2000-01 Northwestern University Alliance for International Development (NU-AID) – Selected
medical students, residents and physicians make a weeklong trip to sites in
South/Central America to assist at clinics and provide care and supplies.

Executive Board/Treasurer (2000-01) – board members plan and coordinate Winter an Summer trips and work to expand the program
to new sites and levels; treasurer overlooks expenditures, fundraising and keeps records of accounts

1999-2001 Devon Clinic Volunteer (1999-2001) -free clinic located in area dominated by Indian immigrants

Asian American Immunization Project – worked to increase awareness about the importance of various immunizations for Asian Americans.

Focus on Indian immigrants and Hepatitis B. Constructed handouts in English and Hindi and held information sessions for the patients at the Devon Clinic.

Follow up is to hold immunization days to actually provide vaccinations.

1999-2000 Camp Wildcat (1999-2000) - a three-day, cost-free camping trip for middle school children from two of Chicago's most underserved neighborhoods - Cabrini Green and Washington Park. Camp Wildcat strives to take these children out of their threatening environments and into a safe place, where they try new activities, explore creative outlets, challenge personal limits, and enhance self-esteem.

Fundraising Coordinator – put together and run fundraisers to raise money for camp wildcat; help with overall organization of programs; act as counselor during camp and supervise children

PURDUE UNIVERSITY

1998-1999 AmeriCorps (1998-1999)

Co-Director of Youth as Resources Program for Tippecanoe, Carroll and Fountain counties, IN. Director is in charge of running program – ie: publicity, brainstorming, fundraising opportunities, outreach, etc.

and works closely with the Board to ensure future and success of program

1996-1999 Volunteer for the Lafayette Crisis Center (1996-1999)

After successful completion of 40 hour training, volunteered for four hours a week at the Lafayette Crisis Center to respond to community callers with emotional distress; listen to caller's concerns and provide crisis intervention and emergency information for various problems, ranging from suicide to rape to mental disorders

Certified Trainer – after mandatory completion of 36 shifts, successfully completed additional trainer workshop and participated as trainer in future training sessions in addition to volunteering at center

Research Accomplishments:

- Comparison of latency after PPROM in multiple gestations versus singleton pregnancies
  Institution: Beth Israel Deaconess Medical Center/Harvard
  - Wrote IRB and recently received approval. Chart review in progress.

- Pharmacy Provision of Medical Abortifacients in Cuernavaca, Mexico and surrounding Rural areas, 3/2006-present

Institution: National Public Health Institute of Mexico
- Abstract accepted at 2007 annual meeting of ARHP
- Paper submitted for Publication

- Abstract: Self administed medical abortion is difficult to study and evaluate. Medications such as Metrigen (estrogen-progesterone), oxytocin, and misoprostol (prostaglandin E1) have been utilized around the world to induce abortion. In countries such as Mexico where elective abortion is illegal, misoprostol is accessible in pharmacies, however, its specific use to self induce abortion is poorly understood. 177 (23%) of the 774 pharmacies registered in the state of Morelos were randomly selected. Between September and December 2006, a trained fictitious client visited each pharmacy, indicated she was pregnant and asked about medications to "induce menstruation." Data were promptly recorded on standardized surveys and complete data sets were obtained from 173 pharmacies. SPSS was used for data analysis. 55% pharmacies spontaneously recommended an abortifacient, 36% of which recommended misoprostol. Of these, 29% provided incorrect dosing or information. No correlation existed between the provision of misoprostol, the age or sex of the pharmacy employee, the type of pharmacy (chain vs. independent), or location (urban vs. rural). The cost was $900-1800 per 28 tablets pesos (~ $4 USD per tablet), and only 6 of 123 pharmacies that offered misoprostol sold loose tablets. A higher percentage of pharmacy employees are aware of misoprostol as an abortifacient than previously reported. However, many are providing incorrect information to women which can have important medical consequences. Cost maybe a significant barrier to its use. Further study is warranted on information acquisition by pharmacists, and novel approaches to information dissemination to women should be investigated.

❖ Adolescent Livelihoods and HIV Acquisition in Karnataka, India, 2002-2003
Funding: Doris Duke Clinical Research Fellowship
Institution: University of California, San Francisco
Mentor: Dr. Suneeta Krishnan, Ph.D.
- Project served as MPH thesis which was defended 2004
- Abstract: Over 95% of the 42 million people living with HIV are in developing countries and India is the country with the most cases of HIV. Adolescents represent one quarter of the developing world and almost one-third of the Indian population. Despite the fact that most new HIV infections are occurring in young people, their reproductive health needs are poorly understood and ill served. To formulate a sustainable intervention, improve reproductive health needs, and decrease HIV infection, we explored the influence that an adolescents' livelihood in India has on reproductive health access, knowledge, behavior, and services. Cultural and gender roles, socioeconomic constraints, education and societal traditions were explored. The methodology consists of community based qualitative data collection via focus group discussions and in-depth interviews with adolescents and older women. The qualitative data served to identify and explore the major contributors to reproductive health status: early marriage and ideals of love, economic constraints, lack of education, gender stereotypes and sexual power. The data support the hypothesis that an intervention to reduce HIV must include an economic component as well as provide health education and increase access to services. The binding element is social change. Programs will need to work with adolescents through culturally sensitive efforts to address gender and social norms in order to challenge harmful attitudes and behaviors.

❖ Decreasing Maternal Mortality and Unsafe Abortion in Central America, 2000
Funding: Reproductive Health Externship received from Medical Students For Choice
Institution: University of California, San Francisco
Mentor: Dr. Anne Foster-Rosales, Ob/Gyn

- Assisted with grant writing for a project to decrease maternal mortality in Central America., with focus on El Salvador, Guatemala, Honduras, and Nicaragua. The project included abortion education and training for local health care workers, and provision of basic emergency treatments, such as antibiotics, oxytocin, and anticonvulsants. Assisted in writing the Background section of NIH grant proposal to obtain funding for the proposed project. Skills: Extensive literature searches, clinical trials project designing with focus on outcomes research and evidence-based medicine, and grant-writing.

Professional Societies:

2000+ American College of Obstetrics and Gynecology (ACOG) –Student Member
1999+ Phi Beta Kappa
1998+ Mortar Board Honor Society
1997+ Golden Key National Honor Society
1995+ Phi Eta Sigma
1995+ Alpha Chi Sigma (Co-ed Professional Chemistry Fraternity) – Treasurer (1995-96)

Honors and Awards:

2007	ACOG Essay Contest Winner for District I
2006	Resident Teaching Award for BIDMC
2002-2003	Doris Duke Clinical Research Fellowship (UCSF)
2002	Obstetrics and Gynecology Clerkship Honors
2001	Surgery Clerkship Honors
2000	Reproductive Health Fellowship Recipient (Summer 2000)
1999	Art in the Atrium- Northwestern – selected to display ceramic artwork
1999	Purdue Undergraduate Art Exhibition Participant - Ceramics
1999+	Phi Beta Kappa
1998	School of Science Outstanding Student Achievement Award
1998+	Mortar Board Honor Society
1997+	Golden Key National Honor Society
1997	Profiles in Excellence Program
1996	LeaderShape Program
1995+	Phi Eta Sigma
1995+	School of Science Scholar Group
1995	School of Science Merit Scholarship
1995	Hoosier Scholar Scholarship
1995-99	Deans List/Semester Honors

Personal Accomplishments:

2003	Honolulu Marathon
2002	Treasure Island Triathlon
16 years	Piano
11 years	Viola

SUPPLEMENT FORM

PRINT NAME: ILA DAYANANDA DATE: 0 / /08

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. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE/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: Ila Dayananda Date: 02/02/2008

02/04/08 13:

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

Applicant's Signature: Ila Dayanandan **Date:** 02/02/08

Full License Application

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

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.

I authorize the medical school/university listed below to provide any and all information pertaining to my medical education at your institution.

Applicant's Signature: Ila Dayananda Date of Birth ____ ____ ____

Print or Type Name: DAYANANDA (Last name) ILA (First Name) D. (Middle Initial) Social Security No: ____

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

Name of Medical School: NORTHWESTERN UNIVERSITY FEINBERG SCHOOL OF MEDICINE

Address: 303 East Chicago Avenue City: Chicago, IL 60611 State or Province: IL

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form and forward it, together with a copy of the official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluations) and mail it 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 page 2)

Full License Application

Enrollment and Participation: Our records indicate that

Dayananda	Ila	
(Last name)	(First name)	(Middle initial)

(type or print the applicant's name):

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/30/99	06/02/00	(07/08/02	05/23/03 - Time off)
	08/28/00	06/01/01	07/09/03	05/21/04
	07/09/01	05/24/02	/ /	/ /

The applicant attended 155 **total weeks or** _____ **total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.**

check one ☒ was awarded a degree in Doctor of Medicine on (month/day/year) MAY 21, 2004

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

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education.

All questions must be answered. **If you answer "YES" to any of the questions below, please enclose an explanation.**

	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her medical education?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		

COMMENTS: PLEASE REFER TO DEAN'S LETTER

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: Miroslava Rachuy

Print Name: MIROSLAVA RACHUY

Title: Academic Records Assistant 3

Date: 02/12/08 Telephone: (312) 503-1225

This form will not be accepted unless it is stamped with the institutional seal or notarized.

Commonwealth of Massachusetts Board of Registration in Medicine
560 Harrison Avenue, Suite #G-4, Boston, MA 02118 (617) 654-9810 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: Ila Dayananda Date: 1/9/08

Print or Type Name: ILA DAYANANDA

Name of Institution: BETH ISRAEL DEACONESS MEDICAL CENTER

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: Beth Israel Deaconess Medical Center

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

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

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	1	OB/GYN	6/21/04	6/19/05	yes	ACGME
Residency	2	"	6/20/05	6/25/06	"	"
Residency	3	"	6/26/06	6/24/07	"	"
Residency	4	"	6/25/07	6/20/08	"	"

(Continued on page 2)

APPLICANT'S NAME: ILA DAYANANDA

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: [signature]

Print Name: Hope Ricciotti

Academic Title: Residency Program Director

Telephone: (617) 667-2285 Today's Date: 1/9/08

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

RECEIVED

FEB 12 2008

Board of Registration in Medicine

MALPRACTICE HISTORY

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

MALPRACTICE HISTORY

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

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

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

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

Liability Carrier: CRICO-RMF
City: 101 Main St Cambridge State: MA 02142
From: 6 /2001 To: 7p /2008
Policy Number: CCAYM-CLAYM-C-GLPL-11 39-2008

Liability Carrier: _____
City: _____ State: _____
From: ____/____ To: ____/____
Policy Number: _____

Liability Carrier: _____
City: _____ State: _____
From: ____/____ To: ____/____
Policy Number: _____

Applicant's signature: Ila Dayananda
02/07/2008
Date

Print Name: ILA DAYANANDA

Address: _____ City: _____

State: _____ Zip code: _____

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

Massachusetts Physician Renewal Application

Physician Name: Ila D Dayananda, M.D. **License No.:** 235025

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PART A

1) Current Status: Active **Renewal Due Date:** 10/17/2008 **Birth Date:**

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

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

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

2a) MAILING ADDRESS

☐ *Check here to change this address*

Please make corrections (print)

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

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Board of Registration in Medicine

2c) BUSINESS ADDRESS

Beth Israel Deaconess Medical Center
330 Brookline Avenue
Boston, MA 02215

Phone: (617)667-2285

☒ *Check here to change this address*

Business Address: 1620 Tremont St, 4th Floor

City/Town: BOSTON, MA State: ~~02120~~ MA

Zip: 02120 Country: USA

Business Telephone: (617) 525 9333

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

Correct your E-mail and Fax Number below:

617-525-7746

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Ila D Dayananda, M.D. **License No.:** 235025

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(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts:

b) Federal (DEA):

c) Federal (DEA) XS:

Please make corrections as necessary

8) Other states where you are now licensed to practice

9) States where you were previously licensed

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
Brigham & Women's Hospital	BOSTON	MA	☐
Planned Parenthood League of MA	BOSTON	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 0 hrs/wk Change to: _____ hrs/wk

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

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

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

Current Insurance Carrier: Change to: CRICO-RMF

Policy dates: From 7/1/2008 To 12/31/2008

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

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

☐ **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: Ila D Dayananda, M.D. **License No.: 235025**

02/19/08 SS 4

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 N/A

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: Ila D Dayananda, M.D. **License No.: 235025**

09/19/08 SS

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: Ila Dayananda Date: 9/15/08

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

FREQUENTLY ASKED QUESTIONS
REGARDING OFFICE BASED SURGERY- FORM PCA-O

Question #1:
"If I only do simple office procedures like freezing warts for removal, suturing simple lacerations, bone marrow biopsies, and I&D, under local anesthesia, do I have to fill out the form?"

Local Anesthesia is Level I. Thus, you need only check the Level I box and sign the form. You do not need to fill out the form it its entirety for the questions on the form are related to Level II and Level III Office Based Surgeries. The offices doing more than local anesthesia must determine what level they are and then fill out the form in its entirety. Guidelines for determining levels are available at: www.massmedboard.org

Question #2:
"I work in an Emergency Department and I give conscious sedation, do I have to fill out the form?"

The form is for office-based surgery. The Emergency Department is not an office; it is a department in a hospital. If the physician has a private office outside the Emergency Department, they need to fill out the form, and guidelines are available at: www.massmedboard.org

Question #3:
"If I have a Massachusetts license, but practice outside Massachusetts, in another state, and that practice includes Level II or III office based surgery, do I have to fill out the form?"

You only have to fill out the form if you perform office-based procedures in Massachusetts.

Question #4:
"I work in an office based surgery practice, but I do not perform office based surgery. Do I have to fill out the form?"

No, you do not need to fill out the form if you do not perform office based surgery or assist in the performance of office based surgery.

Question #5
"I work in a diagnostic and treatment center and my friend works in an ambulatory surgery center, do we need to fill out the form?"

You do not need to fill out the form if you perform procedures in a Massachusetts hospital, and/or diagnostic and treatment center, including ambulatory surgery centers. If you perform the Level I, II or III procedures in a private office at any time, you must fill out the form.

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ila D Dayananda, M.D. **License No.:** 235025

Current Status: Active **License Expiration Date:** 11/14/2010

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

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**
None Reported

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

WorkSite	Location
Beth Israel Deaconess Medical Center	Boston
Brigham & Women's Hospital	Boston

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 24 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Federal Tort Claims Act	01/01/2010	12/31/2010	Claims made with tail coverage
CRICO	01/01/2010	12/31/2010	Claims made with tail coverage

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Ila D Dayananda, M.D. **License No.:** 235025

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 physical 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.**