

REDACTED COPY

Application #: 213684
Date of Issue: _____



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

#200281
G/PMW
3/26/02

FULL LICENSE APPLICATION

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

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

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

RYNTE TIMOTHY EDWARD
Last Name (type or print clearly) First Middle Suffix (Jr., etc.)

M.D. D.O. Ph.D. Other degree B.S.

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

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

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

Place of Birth: DETROIT MI
City State/Province/Territory Country If not USA

Home Address: _____
Number and Street
City State/Province/Territory Zip (or postal) Code

Business Address: 622 W 168 ST PH16E
Number and Street
NEW YORK, NY 10032
City State/Province/Territory Zip (or postal) Code

Business Telephone: (212) 305-2376, ext. _____ Home Telephone: _____

Preferred Mailing Address: Business Address Home Address

PRINT NAME: TIMOTHY RYNTZ

Pre-medical School

Facility: UNIVERSITY OF MICHIGAN Degree: BS From 9/1 / 90 To 12/1 / 93
Street: 500 S STATE ST City: ANN ARBOR State: MI

Facility: _____ Degree: _____ / / / /
Street: _____ City: _____ State: _____

Medical School

Facility: SAINT LOUIS UNIVERSITY Degree: MD From 8/1 / 94 To 6/16 / 98
Street: 1402 S GRAND BLD City: ST LOUIS State: MO

Facility: _____ Degree: _____ / / / /
Street: _____ City: _____ State: _____

Date of medical school graduation: 6/16/98

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

Postgraduate Education:

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

Facility: NEW YORK PRESBITERIAN HOSP. Position: PGY 1-4 From 7/1 / 98 To PRESENT
Street: 622 WILCOX ST City: NEW YORK State: NY

Facility: _____ Position: _____ / / / /
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
Street: _____ City: _____ State: _____

Facility: _____ Position: _____ / / / /
Street: _____ City: _____ State: _____

PRINT NAME: TIMOTHY RYNTZ

Hospital Affiliations and Employment

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

	<u>From</u>	<u>To</u>
Facility: <u>NEW YORK PRESBYTERIAN HOSPITAL</u>	<u>7 / 1 / 98</u>	<u>6 / 30 / 02</u>
Street: <u>622 W 116TH ST</u>	City: <u>NEW YORK</u>	State: <u>NY</u>
Facility: _____	Position: _____ / /	_____ / /
Street: _____	City: _____	State: _____
Facility: _____	Position: _____ / /	_____ / /
Street: _____	City: _____	State: _____
Facility: _____	Position: _____ / /	_____ / /
Street: _____	City: _____	State: _____

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

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

3. List Board Certification(s): _____

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

5. Reason for requesting a Massachusetts medical license: I HAVE ACCEPTED A JOB WITH THE MASSACHUSETTS GENERAL HOSPITAL DEPARTMENT OF OB/GYN


6. Name of Facility: MASSACHUSETTS GENERAL HOSPITAL

7. Address: 70 BLOSSOM ST City: BOSTON

8. Anticipated starting date in Massachusetts: 8 / 1 / 02

Affidavit of Applicant

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


Signature of Applicant

2/15/02
Date

TIMOTHY E. RYNTZ, M.D.

(W) 212-305-2376

Residency: 1998-Present
The New York Presbyterian Hospital
New York, NY
Columbia-Presbyterian Campus
Obstetrics and Gynecology

Education: 1994-1998
Saint Louis University School of Medicine
St. Louis, MO
M.D. Degree 1998

1990-1993
University of Michigan
Ann Arbor, MI
B.S. Degree 1993
Major: Chemistry
Magna Cum Laude Graduate, Phi Beta Kappa, Branstrom Freshman Prize

Previous Employment: 1992-1994
Research Assistant
Dr. Matt Kluger, Ph.D.
Lovelace Institutes, Albuquerque, NM
Maintained WEHI and B9 cell lines, performed TNF and IL-1 bioassays

1992
Research Assistant
Dr. Linda Samuelson, Ph.D.
University of Michigan, Department of Physiology
Maintained transgenic mouse line, performed PCR, Northern and Southern blotting techniques

Research: 1995
"TNF Modulation of Fungal Sepsis during Immunosuppression"
Andrew J. Lechner, Ph.D.
Saint Louis University, Department of Pharmacology and Physiology

Professional Organizations:
American College of Obstetrics and Gynecology, Junior Fellow
American Association of Gynecologic Laparoscopists

Extracurricular Activities:
Chairman, District II, Section 1 ACOG Junior Fellows
Planned Parenthood, Volunteer
Medical Biochemistry Tutor
Piano
Proficient in Spanish

SUPPLEMENT FORM

PRINT NAME : TIMOTHY RYNTZ DATE: 2 / 15 / 02

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

YES NO

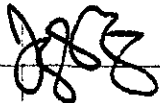
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?
2. Have you ever been terminated or granted a leave of absence by a medical school or medical post-graduate training program or have you ever withdrawn from a medical school or medical postgraduate training program or had to repeat a year of postgraduate training?
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners or any foreign licensing or certification body?
- 6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?
- 6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?
7. Have you ever, for any reason, lost American Board of Medical Specialty certification or been denied required recertification by one or more specialty boards?
- 8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).
- 8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?

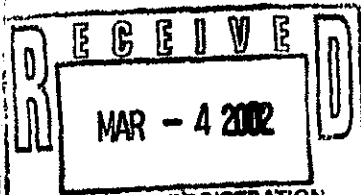
PRINT NAME:

TIMOTHY RYNTZYES NO

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

Applicant's Signature:

Date: 2 / 15 / 02



FULL LICENSE APPLICANT

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

Waiver for Release of Information

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

Applicant's Signature: [Handwritten Signature]

Date of Birth _____

Print or Type Name: RINTZ TIMOTHY E Social
(Last name) (First Name) (Middle Initial)

Security No _____

Other Name(s) _____

Name of Medical School: SAINT LOUIS UNIVERSITY
(Please print name(s))

Address: 1402 S. GRAND BLVD. City: ST LOUIS
State or Province: MO 63104

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

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

If yes, indicate where the applicant completed premedical school.

Applicant's Undergraduate School: _____

Continued on page 2

J.D.C.
4/12/02

FULL LICENSE APPLICANT

(Print last name)

(First name)

(Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/15/94	5/12/95	6/23/97	1/1
	8/14/95	5/10/96	5/19/98	1/1
	7/8/96	6/12/97		

The applicant attended 4 years total weeks of continuing on-campus education, not less than 32 weeks in each academic year and 36 ea. year

check one was awarded a degree in Medicine (M.D.)
 on (month/day/year) 5/16/98

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

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

YES NO

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

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

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

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

Signature: Sally S. Ward
 Print Name: SALLY S. WARD
 Title: REGISTRAR
 Date: 2/22/02
 Telephone: (314) 577-8216

172000001 12

VERIFICATION

POSTGRADUATE

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [Signature] Date: 1/31/02

Print or Type Name: TIMOTHY RYNTZ

Name of Institution: NEW YORK PRESBYTERIAN HOSPITAL

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 to the Board.

Name of Institution: New York Columbia Presbyterian Hospital

If name of Institution was different when applicant attended, please enter name: _____ participated in the following program:
Enrollment and Participation: Our records indicate that Dr. Timothy Ryntz (type or print applicant's name)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department (Obg, Internal medicine, etc.)	Dates Attended (MONTH/DAY/YEAR) FROM TO		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
Intern	PGY-1	OB/GYN	7/1/98	6/30/99	yes	ACGME
Resident	PGY-2	OB/GYN	7/1/99	6/30/00	Yes	ACGME
Resident	PGY-3	OB/GYN	7/1/00	6/30/01	Yes	ACGME
Resident	PGY-4	OB/GYN	7/1/01	6/30/02	Yes	ACGME

Continued on page 2

TDg
4/12/02



POSTGRADUATE

VERIFICATION
APPLICANT'S NAME: TIMOTHY RYAN TZ

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: _____

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Jodi P. Lerner M.D.

Print Name: Jodi P. Lerner, M.D.
Academic Title: Director of Resident Education
Telephone: (212) 305-2376 Today's Date: 2/1/02

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

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

Commonwealth of Massachusetts - Board of Registration In Medicine
10 West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
Fax: (617) 426-9358 Website address: 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. 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.

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. The liability carrier must return this form directly to the Board at the above address.

Liability Carrier: MCIC VERMONT, INC From: 07/98 To: 06/02
City: NY State: NY Policy Number: PR1102

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

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

Applicant's signature: [Signature] Date: 1/31/02

Print Name: TIMOTHY RYNEZ

Address: _____ City: _____

State: _____ Zip code: _____



Physician Registration Renewal Application

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

JAN - 2 2003

- Remit \$400.00 for renewal fee (non-refundable).
- Add late fee of \$25.00, if necessary.

- Return renewal application in GREEN envelope.
- Enclose check with coupon in BLUE envelope.

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

1. Current Status: Active Registration No.: 213684 Renewal Date: 02/24/2003

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

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

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

Please make corrections (print)

<input type="checkbox"/> Other Name(s)	<input type="checkbox"/> Name Change (enter name below)
Mailing Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Business Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Business Telephone: (____) _____	
Home Address: _____	
City/Town: _____	State: _____
Zip: _____	Country: _____
Home Telephone: (____) _____	
PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.	

A) Mailing/Business Address:

3. Timothy E Rvntz

B) Home Address:

Home Phone:

Business Phone: (617)523-2108

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

c) SS#: _____

5. a) Name of Medical School: University School of Medicine

b) Year Graduated: M.D. c) Degree: 1998

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

Code(s)	Hours per Week in Mass.
OBG	40
	0

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

8. Drug License Numbers, if any:

- a) Federal (DEA): St. Louis
b) Massachusetts: _____

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

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

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

Facility Code: 168 / (AP) 100 % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %
Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ % Facility Code: _____ / _____ (AP) _____ %

If 999, print name(s): _____

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz

License No.: 213684

PART A

1) Current Status: Active

Renewal Due Date: 01/27/2005

Birth Date:

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

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) MAILING ADDRESS

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

Check here to change this address

2b) HOME ADDRESS

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

Home address cannot be a Post Office Box

Phone:

Check here to change this address

2c) BUSINESS ADDRESS

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

Business address cannot be a Post Office Box

Phone:

Check here to change this address

3) E-mail Address: _____

4) Fax Number: _____

RECEIVED
2004 DEC 17 PM 1:30
BOARD OF REGISTRATION
IN MEDICINE

5) Specialties (See Renewal Instructions, page 4.)	Delete?	Additional specialties:
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:				Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA		Certificate/Subspecialty	Correct?	Delete?	
OBSTETRICS & GYNECOLOGY	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Obstetrics & Gynecology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz

License No.: 213684

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

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

Principal Work Setting: Hospital

Change to: _____ Hours per Week: _____

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

No Affiliations

Health Care Facility <i>(See Renewal Instructions, page 4.)</i>	Delete?	Staff Category		# Hours per Week
		Current	Change	
Massachusetts General Hospital	<input type="checkbox"/>	<u>ADMITTING</u>		<u>40</u>
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: _____ hrs/wk

b) outpatient care 20 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier *(complete below)*

Current Insurance Carrier: CRICO Change to: _____

Policy dates: From 8 / 1 / 02 To 12 / 31 / 05
(required)

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

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

Check one:

Not involved with direct or indirect patient care in Massachusetts

Government Employee Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz

License No.: 213684

13) Do you perform any surgery in your office? <i>(See Renewal Instructions, page 5.)</i> If <u>Yes</u> , please complete Form PCA-O "Office Based Surgery"	Yes	No
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In questions 14-21, the phrase "time period" refers to the following: all time from the day you signed your last license renewal/application, to the day you sign this renewal application, inclusive. *(See Renewal Instructions, page 5.)*

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

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz

License No.: 213684

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

Signature: _____

Date: 12 / 10 / 04

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

12/21/04 TUE 11:42 FAX

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryztz

License No.: 213684

(See Renewal Instructions, page 4.)

7) Drug License Numbers, if any:

- a) Massachusetts:
- b) Federal (DEA):
- c) Federal (DEA) XS:

Please make corrections as necessary

8a) Other states where you are now licensed to practice (Abbr.)

NY

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

NY

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

Principal Work Setting: Hospital

Change to:

HOSPITAL

Hours per Week:

40

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

No Affiliations

Health Care Facility (See Renewal Instructions, page 4.)	Delete?	Staff Category		# Hours per Week
		Current	Change	
Massachusetts General Hospital	<input type="checkbox"/>	ADMITTING		40
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			
	<input type="checkbox"/>			

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

Average weekly hours involved in: a) inpatient care 20 hrs/wk Change to: _____ hrs/wk
 b) outpatient care 20 hrs/wk Change to: _____ hrs/wk

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

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

Insurance Carrier (complete below)

Current Insurance Carrier: CRICO

Change to: _____

Policy dates: From 8/1/02 To 12/31/05
(required)

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

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

Check one:

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

01/17/07 9:11

PART A

1) **Current Status:** Active **Renewal Due Date:** 01/27/2007 **Birth Date:**

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

Active Retiring Inactive Do not wish to renew

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

2a) MAILING ADDRESS

Please make corrections (print)

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

Check here to change this address

2b) HOME ADDRESS

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

Home address cannot be a Post Office Box

Phone:

Check here to change this address

2c) BUSINESS ADDRESS

P.P.N.Y.C.
 26 Bleecker Street
 New York, NY 10012

Phone: (212)965-7065

Check here to change this address

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

Business address cannot be a Post Office Box

3) **E-mail Address:** _____

4) **Fax Number:** 212-274-7218

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

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.

01/17/2011 11:13

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

01/17/07 91 10

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

Signature: _____



Date: 12/28/06

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

01/17/07 8:15



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Massachusetts Board of Registration in Medicine Physician Profile

Timothy E. Ryntz, M.D.

I. Physician Information

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

License Status: Active
License Issue Date: 4/24/2002
Accepting New Patients: Yes
Accepts Medicaid: Yes
Primary Work Setting: ~~Hospital~~ CLINIC (ONLY CORRECTIONS)
Business Address: P.P.N.Y.C.
 26 Bleecker Street
 New York, NY 10012
Phone: (212) 965-7065
Translation Services Available: None Reported
Insurance Plans Accepted: None Reported
Hospital Affiliations: ~~Massachusetts General Hospital (Admitting)~~ NONE

II. Education & Training

Medical School: St. Louis University School of Medicine
Graduation Date: 1998
Post Graduate Training: None Reported

III. Specialty

Area of Specialty: Obstetrics and Gynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

<u>Board Name</u>	<u>General Certification</u>	<u>Subspecialty</u>
-------------------	------------------------------	---------------------

Obstetrics & Gynecology Obstetrics and Gynecology

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

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

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

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

Dr. Ryntz has not made a payment on a malpractice claim in Massachusetts in the

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past ten years.

VIII. Disciplinary and/or Criminal Actions

A. Criminal Convictions, Pleas and Admissions:

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

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

B. Hospital Discipline:

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

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

C. Board Discipline:

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

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

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

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

Please read the Board of Registration in Medicine Disclaimer



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• [privacy policy](#) • [site map](#)

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

01/19/07 3:11 PM

PART A

1) Current Status: Active **Renewal Due Date:** 01/27/2007 **Birth Date:**

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

Active Retiring Inactive Do not wish to renew

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

2a) MAILING ADDRESS

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

2c) BUSINESS ADDRESS

P.P.N.Y.C.
 26 Bleecker Street
 New York, NY 10012

Phone: (212)965-7065

Check here to change this address

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

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: 212-274-7218

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:		Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.	
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

01/19/07 09:17 AM

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

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

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

Signature: _____

Date: 12/28/06

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

NATIONAL PROVIDER IDENTIFIER (NPI)

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

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

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

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

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

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

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

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

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

My current NPI is:

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

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

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

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

HIPAA TAXONOMY CODES

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

Taxonomy (Specialty) Code

Taxonomy Description (Print)

Primary Provider Taxonomy:

OB/GYN - GYNCOLOGY

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):

MI

Country of Birth (if outside the US): _____

Gender: Male

Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

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

Signature: _____

Date: 12 / 28 / 06

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

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PART A

1) **Current Status:** Active **Renewal Due Date:** 01/27/2009 **Birth Date:**

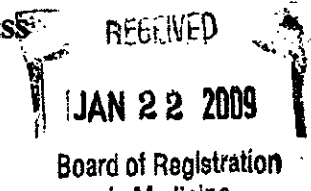
If you want to change your current status, please check one of the following boxes to indicate your new status:
Check only one: (See Renewal Instructions, page 3.)

Active Retiring Inactive Do not wish to renew

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

Please make corrections (print)

2a) **MAILING ADDRESS**



Board of Registration in Medicine

Check here to change this address in Medicine

2b) **HOME ADDRESS**

Phone: _____

Check here to change this address

2c) **BUSINESS ADDRESS**

P.P.N.Y.C.

26 Bleecker Street
New York, NY 10012

Phone: (212)965-7065

Check here to change this address

3) **E-mail Address:** _____

4) **Fax Number:** 212-274-7218

Mailing Address: _____

City/Town: _____ **State:** _____

Zip: _____ **Country:** _____

Home Address: _____

City/Town: _____ **State:** _____

Zip: _____ **Country:** _____

Home Telephone: (____) _____

Home address cannot be a Post Office Box

Business Address: 5191 BROADWAY

City/Town: NEW YORK **State:** NY

Zip: 10034 **Country:** USA

Business Telephone: (212) 932-4200

Business address cannot be a Post Office Box

Correct your E-mail and Fax Number below:

5) Specialties (See Renewal Instructions, page 4.)	Delete?	List Additional Specialties:
Obstetrics and Gynecology	<input type="checkbox"/>	
	<input type="checkbox"/>	
	<input type="checkbox"/>	

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

List Certifying Board(s) below:	Update General Certificates and Subspecialty Certificates below. Please add additional Certifications as required.		
Board Name	ABMS or AOA	Certificate/Subspecialty	Delete?
Obstetrics & Gynecology	ABMS	Obstetrics and Gynecology	<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

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

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

List the names of all work sites in Massachusetts <i>(See above and description on page 4.)</i>	Location (City or Town)	State	Delete?
NONE			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

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

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

b) outpatient care 20 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: ProMutual Group Change to: _____

Policy dates: From ___/___/___ To ___/___/___

Type of Policy: Claims made with tail coverage Occurrence Policy

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

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

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

Check one: Not involved with direct or indirect patient care in Massachusetts

A Government Employee under Federal Tort Claims Act (FTCA)

Otherwise exempt *(Please explain):* _____

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

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

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

YES NO

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

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

Massachusetts Physician Renewal Application

Physician Name: Timothy E Ryntz, M.D.

License No.: 213684

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PART C

Check One:

PHYSICIAN PROFILE

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

CERTIFICATIONS

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

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

Signature: _____

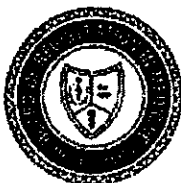
Date: 1/5/09

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.



• online services • agencies • electronic forms

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Massachusetts Board of Registration in Medicine Physician Profile

Timothy E. Ryntz, M.D.

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I. Physician Information

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

License Status:	Active
License Issue Date:	4/24/2002
Accepting New Patients:	Yes
Accepts Medicaid:	Yes
Primary Work Setting:	Clinic / HOSPITAL
Business Address:	P.P.N.Y.C. - NEW YORK PRESBYTERIAN HOSPITAL 26 Bleecker Street 5141 BROADWAY New York, NY 10012 NEW YORK, NY 10034
Phone:	(212) 965-7865 (212) 932-4200
Translation Services Available:	None Reported
Insurance Plans Accepted:	None Reported
Hospital Affiliations:	None Reported

II. Education & Training

Medical School:	St. Louis University School of Medicine
Graduation Date:	1998
Post Graduate Training:	None Reported

III. Specialty

Area of Specialty: Obstetrics and Gynecology

IV. Board Certifications

American Board of Medical Specialties (ABMS)

<u>Board Name</u>	<u>General Certification</u>	<u>Subspecialty</u>
Obstetrics & Gynecology	Obstetrics and Gynecology	

V. Honors and Awards

This physician has reported no awards.

VI. Professional Publications

This physician has reported no publications.

VII. Malpractice Information

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

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

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

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

VIII. Disciplinary and/or Criminal Actions

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A. Criminal Convictions, Pleas and Admissions:

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

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

B. Hospital Discipline:

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

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

C. Board Discipline:

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

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

Additional information about a physician, including closed complaints, may be available by calling the Massachusetts Board of Registration in Medicine
Phone 781-876-8230
Toll Free Number (Massachusetts only) 1-800-377-0550

Return to
Physician Profile Search
Direct questions and comments about these results to
Massachusetts Board of Registration in Medicine
200 Harvard Mill Square, Suite 330, Wakefield, MA 01880
Phone 781-876-8200
For direct response please use Email

Please read the Board of Registration in Medicine Disclaimer

