

Application #: 242461
Date of Issue: / /

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

FULL LICENSE APPLICATION

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

Nov 8 2009
Board of Registration
in Medicine

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

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

ROMANOS CATHERINE EILEEN
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: _____ Social Security Number: _____
Month Day Year

Place of Birth: TORRINGTON CT
City State/Province/Territory Country if not USA

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: 34 Haverhill St Telephone: 978-689-6451
Number and Street

Lawrence MA 01841
City State/Province/Territory Zip (or postal) Code

E-mail Address: _____ Fax number: 978-681-5943

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

* The Board will use your Mailing Address for all correspondence

CK.# 273
11/10/09
WZ

PRINT NAME: CATHERINE ROMANOS

01/04/10 8
7

Pre-medical School

Facility: New York University Degree: BA From 9/1/97 To 5/31/01
Street: 7 E. 12th St City: NEW YORK State: NY

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

Medical School

Facility: University of Connecticut Degree: MD From 8/1/03 To 5/31/07
Street: Farmington Ave City: Farmington State: CT

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

Date of medical school graduation: 05 / 13 / 2007
Month Day Year

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

Postgraduate Education:

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

From To
Facility: Greater Lawrence Family Health Position: PGY 1 6/15/07 6/14/08
Street: 34 Haverhill St City: Lawrence State: MA

Facility: Greater Lawrence Family Health Position: PGY 2 6/15/08 6/14/09
Street: 34 Haverhill St City: Lawrence State: MA

Facility: Greater Lawrence Family Health Position: PGY 3 6/15/09 6/30/10
Street: 34 Haverhill St City: Lawrence State: MA

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.

<u>Examination</u>	<u>Most Recent Date taken (Month/Year)</u>	<u>Passed (P) or Failed (F)</u>		<u>Number of attempts</u>
USMLE Step I	6/2005	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	1
USMLE Step II	6/2006	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	1
USMLE Step III	7/2009	<input checked="" type="checkbox"/> P	<input type="checkbox"/> F	1
NBME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Component 1		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Component 2		<input type="checkbox"/> P	<input type="checkbox"/> F	
FLEX Pre-1985		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
NBOME Part III		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 1		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 2		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMLEX Level 3		<input type="checkbox"/> P	<input type="checkbox"/> F	
COMVEX		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Single		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Part I		<input type="checkbox"/> P	<input type="checkbox"/> F	
LMCC - Part II		<input type="checkbox"/> P	<input type="checkbox"/> F	
State Board Exam		<input type="checkbox"/> P	<input type="checkbox"/> F	

(State of examination)

PRINT NAME: CATHERINE ROMANOS

PAGE 4 OF 5

Hospital Affiliations and Employment

n/a

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.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	/ /	/ /
Street: _____	City: _____	State: _____	
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): _____ Certification date: ____/____/____

_____ Certification date: ____/____/____

4. List your practice specialt(ies) Family Medicine ② 11/11/09

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

6. Reason for requesting a Massachusetts medical license: Wish to practice Family Medicine in MA

7. Name of Facility: Greater Lawrence Family Health Center
Address: 34 Haverhill St City: Lawrence

8. Anticipated starting date in Massachusetts: 7/01/10

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

[Signature]
Signature of Applicant

11 / 5 / 09
Month Day Year

(Continued on page5)

PRINT NAME: CATHERINE ROMANOS

01/04/10 8 11

Hospital Affiliations and Employment

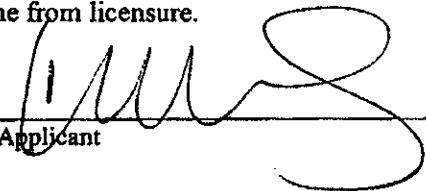
n/a

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.

		<u>From</u>	<u>To</u>
Facility: _____	Position: _____	_/_/	_/_/
Street: _____	City: _____	State: _____	
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): _____ Certification date: _/_/_
 _____ Certification date: _/_/_
4. List your practice specialt(ies) _____
5. Have you attached an up-to-date copy of your curriculum vitae? Yes No
6. Reason for requesting a Massachusetts medical license: Wish to practice Family Medicine in MA
7. Name of Facility: Greater Lawrence Family Health Center
 Address: 34 Haverhill St City: Lawrence
8. Anticipated starting date in Massachusetts: 7/01/10

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

Signature of Applicant 

11 / 5 / 09
Month Day Year

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

01/04/10 9 12

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 were required to obtain an NPI by May 23, 2007.

You must supply the Board of Registration in Medicine with your valid NPI. If you do not have an NPI number, you can apply for an NPI directly by using the NPPES web site at www.NPPES.cms.hhs.gov.

My current NPI is:

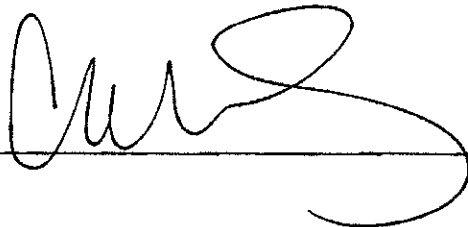
1	6	5	9	5	7	4	1	9	2
---	---	---	---	---	---	---	---	---	---

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.

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

Signature: _____



Date: _____

11 / 5 / 09

CATHERINE ROMANOS

Email:
Phone: (

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16

EDUCATION

- Greater Lawrence Family Medicine Residency, Lawrence, MA** June 2007 - July 2010
Family Medicine Residency
- Greater Lawrence Family Medicine Residency, Lawrence, MA** March 2009 - March 2010
Chief Resident
- University of Connecticut School of Medicine, Farmington, CT** August 2003 - May 2007
Doctor of Medicine
- New York University, College of Arts and Science** September 1997 - May 2001
B.A. Spanish Literature, Honors Program, *Minors: Biology, Chemistry, Fine Arts*
GPA: 3.7 - *Magna Cum Laude*

SPANISH LANGUAGE TRAINING

- The Rassias Foundation Summer Language Program at Dartmouth University** June 2007
Participated in 10 day intensive immersion program for teachers of Spanish
- The Summer Seminars Abroad for Spanish Teachers at Ohio State University, Granada Nicaragua** July 2009
2 weeks masters level course in Spanish linguistics for graduate students and teachers of Spanish
- Universidad de la Complutence de Madrid** January 2000 - June 2000
New York University in Madrid August 1999 - May 2000
Participated in combined study abroad program.

WORK EXPERIENCE

- Project Coordinator, Community Outreach Program** June 2001 - June 2003
Albert Einstein Cancer Center, Albert Einstein College of Medicine - Bronx, NY
Coordinated a multidisciplinary program providing cancer education and prevention to the Bronx community as well as psychosocial support for cancer patients and their families. Facilitated six week smoking cessation group program for both English and Spanish speaking patients. Performed cancer prevention puppet shows and talk shows for students in the Bronx public school system.
- Research Assistant, Cornell Medical College - New York, NY** October 1998 - August 1999
Assisted a psychiatrist in psychiatric research; performed laboratory tasks; analyzed data; reviewed pertinent literature; edited papers; created data presentations.

COMMUNITY SERVICE

- Director, South Park Inn Homeless Shelter Clinic - Hartford, CT** May 2006 - Present
Supervised the volunteer activities of hundreds of medical students and dozens of physicians serving at a free medical clinic located within a homeless shelter. Acted as liaison to University of Connecticut Health Center administration.
- Director of Women's Health Services, South Park Inn Homeless Shelter Clinic - Hartford, CT** May 2004 - April 2006
Created and implemented a monthly acute care women's clinic in a homeless shelter. Recruited a team of physicians and medical students to staff the clinic. Simultaneously implemented women's health educational series to promote resident attendance in clinic.
- Teacher, Hartford Health Education Project - Hartford, CT** Spring 2005
Taught six week course in health education to bilingual third and fourth graders in Hartford public school on nutrition, violence prevention, conflict resolution, puberty and reproduction.
- Volunteer, UCONN Medical Student Free Clinics - Hartford, CT**
YMCA Girl's Shelter Clinic - 2003-Present, South Marshall Salvation Army Shelter Clinic for Women and Children - 2003-2004, Migrant Farm Worker's Clinic - 2003-2004
UCONN students have established several student-run clinics providing acute care and referral services to Hartford area homeless shelter residents and migrant farm workers.

PUBLICATIONS/POSTERS

Posters

Allen R, Beben K, Chuck T, DiMaria C, Kalish M, Kopyt L, Lee J, Leytin V, Romanos C, Rowe B, Slitt G, Gould B. Care of the Patient With Diabetes Mellitus, a Continuing Quality Improvement Project at an Urban Health Clinic. Presented at the University of Connecticut Health Center Annual Continuing Quality Improvement Research Symposium, May 31, 2006, Farmington, CT. Second Place Winner in Student Research Category.

Sivinski J, Lukoschek P, Romanos C, Fazzari M, Hernandez A. Poster/Text Analysis of Children's Health Beliefs and Knowledge. Poster presented at the annual conference of the American Psychological Association, July, 2004, Honolulu, Hawaii.

Chatoorang O, Lukoschek P, Romanos C. Children's Health Beliefs Serve as Barriers to Diet and Exercise. Poster presented at 2nd National Steps to a Healthier US, April 29-30, 2004, Baltimore, Maryland.

Romanos C, Lukoschek P, Moadel A. School Participation in a Cancer Prevention Poster Contest. Poster presented at the American Association of Cancer Education 2002 Annual Meeting, October 31-November 3, 2002 in Toronto, Ontario, Canada.

Marino P, Von Bergen HA, Romanos C, Lukoschek P, Moadel A. The Relationship Between Locus of Control, Confidence to Quit, and Tobacco Use. Poster presented at the 27th Annual Meeting of the American Society of Preventive Oncology, March 9-11, 2003, Philadelphia, Pennsylvania.

Publications

Altemus M, Roca C, Galliven E, Romanos C, Murphy D, Deuster P. Increased Vasopressin and ACTH Responses to Stress in the Mid-Luteal Phase of the Menstrual Cycle. *J Clin Endocrinol Metab.* 2001 Jun;86(6):2525-30.

Presentations

Romanos C. Eating Disorder – NOS, a case study. Presentation given at the Multidisciplinary Ambulatory Experience Research Day, February 20, 2006, Farmington, CT.

References available upon request

SUPPLEMENT FORM

PRINT NAME: CATHERINE EILEEN ROMANOS DATE: 11 / 5 / 09

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

QUESTIONS

YES NO

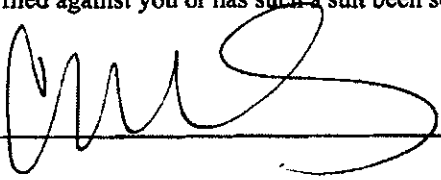
- 1. Since your enrollment in college, have you been subject to any disciplinary action...
2-A. Have you ever been terminated or granted a leave of absence...
2-B. Have you ever, for any reason, been placed on probation...
3. Have you ever applied for licensure or to sit for an examination...
4. Since your enrollment in college, have you been denied the privilege...
5. Have you ever failed any of the following examinations...
6-A. Have you ever, for any reason, been denied a medical license...
6-B. Have you ever voluntarily surrendered a license...
7. Have you ever, for any reason, lost American Board of Medical Specialty...
8-A. Are any formal disciplinary charges pending against you...
8-B. Has any disciplinary action ever been taken against you...

Applicant's Signature: [Handwritten Signature] Date: 11 / 5 / 09

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: _____



Date: 11 / 5 / 09

Enrollment and Participation: Our records indicate that

Full License Application

(Type or print the applicant's name): Romanos

(Last name) Catherine

(First name) Sileen

(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
08/18/2003	06/30/2004	07/01/2006	05/13/2007
08/18/2004	06/30/2005	/ /	/ /
07/01/2005	06/30/2006	/ /	/ /

The applicant attended 144 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

was awarded a degree in MD on (month/day/year) 05/13/2007
 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.

1. Did the applicant take any leaves of absence or breaks from his/her medical education? YES NO
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: [Signature]
 Print Name: SURINDA DAS
 Title: Asst Registrar
 Date: 11/20/09 Telephone: (860) 679-3125

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

Seal Verified
 DATE: 11/25/09
 INITIALS: JJC

NOV 25 2009
 Board of Registrars
 in Medicine

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: [Signature] Date: 9/21/09

Print or Type Name: CATHERINE E. ROMANOS

Name of Institution: Greater Lawrence Family Health 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: Greater Lawrence Family Health Center

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

Enrollment and Participation: Our records indicate that Catherine Romanos 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)		Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited)
			FROM	TO		
Intern	1	Fam Med	6/13/07	6/27/08	yes	ACGME
Resident	2	Fam Med	6/28/08	6/28/09	yes	ACGME
Resident	3	Fam Med	6/29/09	6/29/10	will complete	ACGME

APPLICANT'S NAME: Catherine Romanos

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: Joseph J. Gravel, MD
 Academic Title: Program Director
 Telephone: 918, 725-9410 Today's Date: 9, 24, 05

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

Seal Verified

DATE: 11/09/09

INITIALS: [Signature]

MALPRACTICE HISTORY

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

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 completed 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:

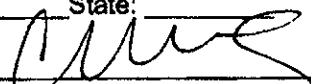
1. the name(s) of the claimant(s)
2. nature and date of claim(s)
3. amounts paid, if any, and
4. other disposition or information in its possession, custody or control on my current policy number, and/or any other policy I have had with this or any other carrier
5. dates of policy coverage must be included.

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: FTCA From: 6 / 07 To: 6 / 10
City: _____ State: _____ Policy Number: _____

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

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

Applicant's signature:  11 / 5 / 09
Date

Print Name: CATHERINE E. ROMANOS
Address: _____ City: _____
State: _____ Zip code: _____

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



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

Current Status: Active

License Expiration Date: 1/28/2011

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 150 Park St
Lawrence
Massachusetts - 01841
United States of America
(978) 314-9495

3) Email Address:

4) Fax Number: (978) 681-5963

5) Specialties
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
		XR1803130

8) Other states where you are now licensed to practice
New York

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
Greater Lawrence Family Health Center	150 Park St
Lawrence General Hospital	



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

11) Care of patients in Massachusetts

Average weekly hours involved in:

- a) inpatient care 10 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier

Federal Tort Claims Act
Federal Tort Claims Act

Policy Start Date

07/05/2010
01/01/2011

Policy End Date

12/31/2010
12/31/2011

Policy Type

Claims made with tail coverage
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?



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

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: Catherine E Romanos, M.D.

License No.: 242461

Compliance with Legal Responsibilities

Online profile:

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.
- 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.
- 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.



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

Current Status: Active

License Expiration Date: 1/28/2015

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 3255 E. Main St
Columbus
Ohio - 43213
United States of America
(614) 222-3531

3) Email Address:

4) Fax Number:

5) Specialties
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
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8) Other states where you are now licensed to practice
Ohio

9) States where you were previously licensed
New York

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
	None Reported



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

11) Care of patients in Massachusetts
Average weekly hours involved in:

- a) inpatient care 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
National Union Fire Ins Co of Pittsburgh	01/01/2014	12/31/2014	Claims made with tail coverage
National Union Fire Ins Co of Pittsburgh	01/01/2015	12/31/2015	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 taken a leave of absence from any health care facility, group practice or employer for reasons related to your competence to practice medicine?
c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?

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

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

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



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

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: Catherine E Romanos, M.D.

License No.: 242461

Compliance with Legal Responsibilities

Online profile:

I have reviewed my Physician Profile and confirm that the information is accurate.

- 1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.
- 2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.
- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq, and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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.

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.



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

Current Status: Active

License Expiration Date: 1/28/2013

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 150 Park St
Lawrence
Massachusetts - 01841
United States of America
(978) 314-9495

3) Email Address:

4) Fax Number: (978) 682-5787

5) Specialties
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS
		XR1803130

8) Other states where you are now licensed to practice
New York

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
Greater Lawrence Family Health Center	150 Park St
Lawrence General Hospital	



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

11) Care of patients in Massachusetts

Average weekly hours involved in: a) inpatient care 10 hrs/wk
b) outpatient care 30 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Federal Tort Claims Act	01/01/2012	12/31/2012	Occurrence Policy
Federal Tort Claims Act	01/01/2013	12/31/2013	Occurrence Policy

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

14) Claims Made

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

15) Claims Closed

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

16) Other Civil Lawsuits

Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.

- a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
- b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

17) Criminal Charges

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

18) Other Issues

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

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

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



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

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

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

Yes



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

- 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: Catherine E Romanos, M.D.

License No.: 242461

Compliance with Legal Responsibilities

Online profile:

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.
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- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when i have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
- 7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.
- 8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.
- 9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.
- 10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.
- 11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L. c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.
- 12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L. c. 112 sec. 12AA.
- 13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.
- 14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.
- 15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

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.

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.



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

Current Status: Active

License Expiration Date: 1/28/2017

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address: 3255 E. Main St
Columbus
Ohio - 43213
United States of America
(614) 222-3531

3) Email Address:

4) Fax Number:

5) Specialties
Family Medicine

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Family Medicine	Family Medicine	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS XR4108228
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8) Other states where you are now licensed to practice
Ohio

9) States where you were previously licensed
New York

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
	None Reported



Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

11) Care of patients in Massachusetts

Average weekly hours involved in:

- a) inpatient care 0 hrs/wk
b) outpatient care 0 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
Marsh USA, Inc	01/01/2016	01/01/2017	Claims made with tail coverage
Marsh USA, Inc	01/01/2017	01/01/2018	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?
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17) Criminal Charges

- a) Have you been charged with any criminal offense during this period?
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18) Other Issues

- a) Have you withdrawn an application to any governmental authority, health care facility, group practice employer or professional association?
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c) Have you been the subject of an investigation by any governmental authority, including the Massachusetts Board of Registration in Medicine or any other state medical board, health care facility, group practice, employer or professional association?
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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?



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

22) Have you completed all of the CPD requirements for this renewal cycle? If you are renewing your license for the first time or participating in postgraduate training, please answer Yes.

Yes



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

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: Catherine E Romanos, M.D.

License No.: 242461

25) Electronic Health Records Proficiency

I have demonstrated proficiency in the use of EHR by employment with, credentialed to provide patient care at, or in a contractual agreement with an eligible hospital or critical access hospital that has a CMS Meaningful Use program.

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse

Have you completed training to recognize and report suspected child abuse or neglect?



**Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application**

Physician Name: Catherine E Romanos, M.D.

License No.: 242461

Compliance with Legal Responsibilities

Online profile:

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.
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- 3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.
- 4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.
- 5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.
- 6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.
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- 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.
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- 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.

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.

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.