Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086
http://www.massmedboard.org

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 *4 weeks* before your renewal date.

- **Remit $250.00 for renewal fee.**
- **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.

REDACTED COPY

1. Current Status: Active Registration No.32195 Renewal Date: 09/14/2001

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:

RECEIVED
SEP 2001
BOARD OF REGISTRATION IN MEDICINE

Please make corrections (type or print)

Other Name(s): _____

3. A) Mailing/Business Address:
GERALD ZUPNICK

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

B) Home Address:

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

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

Home Phone:

Business Phone:

PLEASE NOTE: No P.O. Box addresses for home or business addresses.

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

c) SS#:

5. a) Name of Medical School:

University of Louisville Sch.of Med.,Hlth.Sci.Ctr.

b) Year Graduated: 1968 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
FP	0	Family Practice
GYN	0	Gynecology

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

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

NY CA DC GA FL KY

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

NY CA DC GA FL KY

10. Current health care facilities at which you 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).

Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ %
Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ % Facility Code: ___ (AP) ___ %
If 999, print name(s): _____

PRINT YOUR LAST NAME: ZUPNICK LICENSE NUMBER: 32195

11. My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit
Name of Insurer: MMIA Alternatively, indicate as follows:
I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)
a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt
Please explain exemption: _____
12. Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No
13. A. What is your principal work setting? (See Table 4) 2 5
B. Care of patients in Massachusetts (see instruction booklet).
1) Average weekly hours involved in: a) outpatient care 0 hrs/wk b) inpatient care 0 hrs/wk
2) What is the approximate percentage of your patient care hours in primary care? _____%

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
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 or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. **CME CERTIFICATION:** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No
☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.

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

- ***Pursuant to G.L c. 62C, § 47A, to the best of my knowledge and belief, I am in compliance with M.G.H.C. 119A relating to withholding and remitting Child Support.***
- ***Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.***
- ***I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true.***

Signature: _____ Date: 8/19/01

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

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.
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary.**
- **Return renewal application in GREEN envelope**
- **Enclose check with coupon in BLUE envelope**

RECEIVED SEP 21 1999 Board of Registration in Medicine

RECEIVED OCT 18 1999 Board of Registration in Medicine

Registration No.: 32195 Renewal Date: 09/14/1999 Current Status: Active

If you want to change your current status, please indicate below: (Check one).

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see below *) ☐ Do not wish to renew

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

3. A) Mailing/Business Address:
GERALD ZUPNICK

B) Home Address:

Home Phone:
Business Phone:

4. A) Date of Birth: Sex: M
B) SS#:

5. A) Name of Medical School:
University of Louisville Sch.of Med.,Hlth.Sci.Ctr.

B) Year Graduated: 1968 C) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
~~FP~~	0	~~Family Practice~~
GYN	0	Gynecology

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

8. Drug License Numbers, if any:
A) Federal (DEA):
B) Massachusetts:

9. A) Other states where you are now licensed to practice
Abbr: NY CA DC GA FL KY
B) States where you previously were licensed to practice
Abbr: NY CA DC GA FL KY

Please make corrections (type or print)

A & B

Other Name(s): _____

Mailing Address: _____
City/Town: _____ State: _____
Zip: _____ Country: U.S.A.

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

Home: (____) _____
Business: (____) _____

Date of Birth: (M/D/Y): __/__/__ Sex: ☐ M ☐ F
SS#: __ __ __ - __ __ - __ __ __ __

Full Name of Medical School:
_____
_____

Year Graduated: _____ Degree: ☐ M.D. ☐ D.O.

Code(s)	Hours Per Week in Massachusetts
___ ___ ___	_____
___ ___ ___	_____
If OS, Print Specialty:	_____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___

Abbr: ___ ___ ___ ___

If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.

Signature: _____ Date: 9/15/99

COPY ALL PAGES OF YOUR RENEWAL APPLICATION BEFORE MAILING

DIVISION OF REGISTRATION
ROOM 1520 — 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
BOARD OF REGISTRATION
IN MEDICINE

AS A REGISTERED
PHYSICIAN

IMPORTANT — READ, COMPLETE AND SIGN —
PURSUANT TO M.G.L. C.62C, S.49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO OR FEDERAL ID NO

YOU MUST SIGN BELOW

X _____ APPLICANT'S SIGNATURE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		32195	100.00	100.00	01	15	84	

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT FOLD OR STAPLE THIS FORM

GERALD ZUPNICK

DO NOT WRITE BELOW THIS LINE

MY SIGNATURE ON THIS RENEWAL APPLICATION INDICATES THAT I ATTEST UNDER THE PAINS AND PENALTIES OF PERJURY TO THE COMPLETION OF CONTINUING EDUCATION REQUIREMENTS IN COMPLIANCE WITH THE BOARD'S STATUTES AND/OR RULES AND REGULATIONS.

PLEASE USE THE ENCLOSED RETURN ENVELOPE

Note! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A CERTIFIED CHECK OR MONEY ORDER — PAYABLE TO:

COMM. OF MASS.
P.O. BOX 6
BOSTON, MASS. 02297

UNCERTIFIED PERSONAL CHECKS/BUSINESS CHECKS WILL NOT BE ACCEPTED.

3500600321950 011584 10000000009

1. Principal Specialty(ies): * | 1 | 5 | | 1 | 0 |

2. Principal work setting: * | 3 | 1 |

3. Home Address:

4. Primary work address: 131 FULTON AV
HEMPSTEAD, N.Y. 11550

5. States other than Massachusetts in which you are licensed to practice: NY CA KY FLA

	YES	NO
6. Has a judgement been returned against you in a malpractice suit since 1/15/82?		
7. Have you ever been convicted of any criminal offense other than minor traffic offenses?		
8. Has any disciplinary action been taken against you in this state or any other?		
9. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

10. I have completed my C.M.E. requirements between 1/15/82 & 1/15/84 as follows: * | 0 | 8 |

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE.

SIGNATURE

*SEE CODE SHEET

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

BOARD OF REGISTRATION IN MEDICINE
ROOM 1507 – 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
1986-1988

IMPORTANT — READ, COMPLETE AND SIGN —

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

SOC SEC NO., OPTIONAL

YOU MUST SIGN BELOW

X _____
APPLICANT'S SIGNATURE

SEE REVERSE SIDE

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS, YOU MUST CHECK THIS BOX: ☑

PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		32195	100.00	100.00	01	15	86	

NOTE! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
P.O. BOX 6
BOSTON, MASSACHUSETTS 02297

DO NOT FOLD OR STAPLE THIS FORM

GERALD ZUPNICK

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

OK

3500600321950 011586 10000000004

34

Print Name: GERALD ZUPNICK M.D Date of Birth:

Medical School: UNIV. OF LOUISVILLE Date of Graduation: 6/68

You must read the instructions enclosed with this form to answer questions 1-12.

1. Principal Specialty(ies): FP - GYN
2. Principal work setting PRIVATE OFFICE
3. Home address: SAME AS FRONT
4. Principal business address: SAME AS FRONT
5. List all hospitals at which you have currently effective privileges:
6. States other than Massachusetts in which you are licensed to practice: N.Y. CALIF. KY. GA.

	YES	NO
7. Have you been a defendant in any malpractice suit commenced since 10/1/83?		
8. Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?		
9. Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
10. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

11. I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows: PHYSICIANS REC. AWARD OF AMA 1983

12. I am an active ✓ inactive practitioner. (Check one)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE.

6 MO

SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
32195	ACTIVE	$250.00	09/14/95	$25.00

Mailing Address:

GERALD ZUPNICK, M.D.

Correction of Mailing Address

Address (Mailing): _____

_____

City/Town: _____

State: _____

Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- ***Add late fee if necessary.***
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.

Pre-Printed Information

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

2. Home Address:

3. Date of Birth: Sex: M
   Lic. Issue Date: 04/16/70 SS#:

   Home Phone Business Phone
   .6) 883-2526

4. Name of Medical School:
   University of Louisville Sch.of Med.,Hlth.Sci.Ctr.
   Year Graduated: 68 Degree: MD

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

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

Code	Hours per Week in Mass.	
FP	0	Family Practice
GYN	0	Gynecology

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: Code:

8. Drug license number(s), if any:
   a) Federal (DEA)
   b) Massachusetts

Corrections of Pre-Printed Information

Name: _____

Address: _____

City/Town: _____

State: _____ Zip: _____

Country: _____

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____

Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____

_____

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

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Code Hours per Week in Mass.

_____ _____

_____ _____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____

Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE X INACTIVE ____

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

PRINT NAME AND NUMBER: Physician Last Name: ZUPNICK Registration Number: 32195

10. a) Current health care facility(ies) at which you 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 facilities where you have admitting privileges (AP).

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP) Facility Code: ___ / ___ (AP)

If 999, print name(s): _____

b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3)

Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___ Facility Code: ___

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier X (b) Letter of Credit ___ If applicable, check one.
List Insurer: [redacted] MED. LIABILITY MUTUAL INS. CO. 2 PARK AV.; NYC 10016

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: ___ (ii) Otherwise exempt: ___
State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No X (Check one)

13. a) What is your principal work setting? (See Table 4) 1 5

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

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) 50 %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 by a patient, or been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?		
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?		
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?		
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?		

25. I have completed my CME requirements in the two years preceding my renewal date: Yes X No, waiver requested ___
No, training program exemption (see instruction booklet). ___

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: 9/10/95

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

Registration No.	Status	Fee	Renewal Date	Late Fee
52195	ACTIVE	$250.00	09/14/93	$25.00

Mailing Address:
GERALD ZUPNICK, M.D.

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

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

For Office Use Only
M.R. SEP 15 1993
SEP 15 1993
Pr. _____
Bk/D.E. _____

Pre-Printed Information

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

2. a) Address (Home):

   b) Address (Business):

3. Date of Birth: Sex: M
   Lic. Issue Date: 04/16/70 SS#:
   Telephone Number:
   Home Business
   (510)855-2526

4. Name of Medical School:
   University of Louisville Sch.of Med./Hlth.Sci.Ctr.
   Year Graduated: 68 Degree: MD

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

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

Code	Hours per Week in Mass.	
FP	0	Family Practice
GYN	0	Gynecology

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

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

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

Corrections of Pre-Printed Information

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

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

Full Name of Medical School: _____
_____
Year Graduated: _____ Degree (MD/DO): _____

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

If OS, print specialty: _____

Code: _____ Code: _____

Code: _____ Code: _____

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

Staple Check Here

EN

PRINT NAME AND NUMBER: Physician Last Name: ZUPNICK Registration Number: 32195

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

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

11. My medical malpractice insurance is covered by (a) INSURANCE CARRIER ✓ or (b) LETTER OF CREDIT___ If applicable, check one.
List Insurer: MED. MALPRAC. INS. ASS. 110 WILLIAM ST, NYC 10038

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

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

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

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes___ No ✓ (Check one)

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

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

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

IN THE PAST TWO YEARS:

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

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

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

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

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

Signature: ___ Date: 9/10/93

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1991-1993 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date
52195	ACTIVE	$150	09/14/91

Dr. GERALD ZUPNICK

For Office Use Only

M.R. ____ __/__/__
Pr. ____ __/__/__
Bk. ____ __/__/__
Ch. ____ __/__/__
D.E. ____ __/__/__

ENTERED SEP 19 1991

Directions:

- *Questions 1-7 include information from Board files. Please correct as necessary.*
- *Before proceeding, please read the instruction booklet.*
- *Answer all non-optional questions completely. (The instructions specify which questions are optional.)*
- *Make a copy of this form and all attachments for your own records--you must give health care facilities copies for credentialing purposes. The Board charges $3.00 plus postage for each copy furnished.*
- *Enclose the $150.00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

Activity Status:

I am applying to be registered with the following status: Active X or Inactive ____

I hereby certify that if requesting inactive status, I will not practice medicine in Massachusetts.

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

Name: ____

2. a) Address (Home):

Address: ____
City/Town ____
State: ____ Zip: ____
Country Code: ____ (If 999 write Country): ____

2. b) Address (Business):

Address: ____
City/Town: ____
State: ____ Zip: ____
Country Code: ____ (if 999, write Country): ____

3. Date of Birth: Sex: M
Lic. Issue Date: 04/16/70 SSN #:
Telephone Number:
Home: Business: (516)883-2526

Date of Birth (M/D/Y): __/__/__ Sex (M/F): ____
Lic. Issue Date(M/D/Y): __/__/__ SSN #: ____
Home: (___)____ Business: (___)____

4. Medical School Code: KY002 Year Graduated: 68 Degree: MD
Name of School: University of Louisville Sch.of Med./Hlth.Sci.Ctr.

School Code: ____ Year Graduated: ____ Degree (MD/DO): ____
If 99999, write School: ____

5. a) Other States where you are now licensed to practice (*Abbr*): NY CA DC GA FL
b) States where you previously were licensed to practice (*Abbr*): NY CA DC GA FL

6. Specialty Code(s) *(See Table 3)*:

Code	Hours per Week in Mass.	
FP	0	Family Practice
GYN	0	Gynecology

Code	Hours per Week in Mass.
____	____
____	____

If OS, write specialty: ____

7.a) Are you American Specialty Board Certified? (Y/N) N 7.b) If YES, Enter Codes:
Code:
Code:

Code: ____
Code: ____

8. Drug License Number(s) (if any) (optional): a) Federal (DEA) ____ b) How many DEA nos. do you have? ____
c) State (MA) #M ____

9. I have completed my C.M.E. requirements in the two years preceding my renewal date: YES X Waiver Requested ____
(You must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed.) *See Instructions for CME requirements. Do not submit documentation of your CME's with your renewal application.*

[For Office Use Only: Waiver Granted ____ Date: __/__/__]

FILL IN NAME AND NUMBER:

Physician Last Name: ZUPNICK Registration No.: 32195

10. My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT_____. If applicable, check one.

List Insurer: MED. MALPRAC. INS ASS.; 110 WILLIAM ST, NYC 10038

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*:

(i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE:_____ (ii) OTHERWISE EXEMPT:_____

(State how otherwise exempt):_____

11. Current Hospital Affiliations *(Supply the codes from Table 5 and place a check mark next to those facilities where you have admitting privileges (AP).*

Facility Code: ___/__(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)

Facility Code: ___/__(AP) Facility Code: ___/__(AP) Facility Code: ___/__(AP)

If 999, write Name(s):_____

Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 4 years. *(See Table 5.)*

Facility Code:___ Facility Code:___ Facility Code:___ Facility Code:___

If 999, write Name(s):_____

12. Post Graduate Training in Massachusetts (MA) (See instruction booklet.)

a) Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No X (Check one.)

b) If you are in a MA program, are you a i) Resident____ ii) Clinical Fellow___ or iii) Research Fellow___? (Check one.)

c) How many hours per typical week do you spend in this MA post-graduate training program?_____hrs./wk. in MA.

13. Care of Patients in Massachusetts (MA) (See instruction booklet.)

a) How many hours per typical week are you currently involved in *outpatient* care in MA? 0 hrs./wk. in MA.

b) How many hours per typical week are you currently involved in *inpatient* care in MA? 0 hrs./wk. in MA.

14. Principal Work Setting.

a) What is your principal work setting? (*See Table 6*) 15

Questions 15 through 22 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A.
Refer to the instruction booklet for additional information.

	Yes	No
15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?.....		
16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?.....		
17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?.....		
18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?.....		
19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....		
20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....		
21. Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?.....		
22. Are you now, or have you been in the past four years, dependent upon alcohol or drugs?.....		

Pursuant to M.G.L. c.475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

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

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

Signature:_____ Date 9/10/91

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

Physician Registration Renewal Application

9/16

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. The Board will charge a fee for each copy.
  - **Remit $250.00 for renewal fee.**
  - **Add late fee of $25.00, if necessary.**
  - **Return renewal application in GREEN envelope.**
  - **Enclose check with coupon in BLUE envelope.**

Registration No.: **32195** Renewal Date: **09/14/97** SEP 10 1997

1. Activity Status: (Check only one)
   - ☒ Active
   - ☐ Inactive *(see below)
   - ☐ Retiring (see instructions)
   - ☐ Do not wish to renew

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

3. A) Mailing/Business Address:

GERALD ZUPNICK, M.D.

B) Home Address:

Home Phone:
Business Phone: **(516)883-2526**

4. A) Date of Birth: C) Sex: **M**
   B) Lic. Issue Date: **04/16/70** D) SS#:

5. A) Name of Medical School:

University of Louisville Sch.of Med.,Hlth.Sci.Ctr.

B) Year Graduated: **68** C) Degree: **MD**

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

Code(s)	Hours per Week in Mass.	
FP	**0**	**Family Practice**
GYN	**0**	**Gynecology**

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

8. Drug License Numbers, if any:
   A) Federal (DEA):
   B) Massachusetts:

9. A) Other states where you are now licensed to practice
   Abbr: **NY CA DC GA FL KY**
   B) States where you previously were licensed to practice
   Abbr: **NY CA DC GA FL**

Corrections (type or print)

Other Name(s): _____

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

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

Home: (_____) _____
Business: (_____) _____

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

Full Name of Medical School:
_____
_____

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

Code(s) Hours Per Week in Mass.
___ ___ ___ _____
___ ___ ___ _____
If OS, Print Specialty: _____

Code: _____ Code: _____

Federal (DEA): _____
Mass: _____

Abbr: ___ ___ ___ ___
Abbr: KY ___ ___ ___

***If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts**

PRINT NAME AND NUMBER: Last Name: ZUPNICK Registration Number: 32195

10. A. Current health care facilities at which you 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).

Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP)
Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP) Facility Code:__ __ __/__(AP)
If 999, print name(s): _____

B. Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years. (See Table 3)

Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __ Facility Code:__ __ __
If 999, write Name(s): _____

11. My medical malpractice insurance is covered by a) X Insurance Carrier ____ b) Letter of Credit

Name of Insurer: MLMIC

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a) X Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13. A. What is your principal work setting? (See Table 4) 1 5

B. Care of patients in Massachusetts (see instruction booklet). 0

1) Average weekly hours involved in: a) outpatient care 0 hrs/wk b) inpatient care 0 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care ? 10 %

PART A

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

	YES	NO
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. **CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. *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 been settled, adjudicated or otherwise resolved?*		
17. Have you been charged with any criminal offense, other than a minor traffic violation?		
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		
22. Have you completed your CME requirements preceding your renewal date (see instruction booklet)? ☐ *Waiver requested* (*waiver form due 30 days prior to date of license expiration*). ☐ *Training Program exemption*		

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED.

Signature _____ Date: 8/12/97

BOARD OF REGISTRATION IN MEDICINE

TEN WEST STREET
BOSTON, MASSACHUSETTS 02111
RENEWAL APPLICATION
1987-1989

SOC. SEC NUMBER, OPTIONAL ___-___-____

SEE REVERSE SIDE
YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW AND ON THE REVERSE SIDE OF THIS APPLICATION. (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS.)
IF YOU ANSWERED "YES" TO QUESTIONS 15 THROUGH 24, YOU MUST CHECK THIS BOX: ☒
PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO.			MO	DA	YR	
MD	1	32195	$100	100	09	14	87	

NOTE! **THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT. A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED. PERSONAL CHECKS ARE ACCEPTABLE.**

PAYABLE TO:
COMMONWEALTH OF MASSACHUSETTS
TEN WEST STREET, 2nd FLOOR
BOSTON, MASSACHUSETTS 02111

GERALD ZUPNICK

250

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS 1-26.

1. Print Name: GERALD ZUPNICK
2. Date of Birth: ___ MONTH ___ DAY ___ YEAR
3. Medical School: UNIV OF LOUISVILLE M.D.? ☒ D.O.? ☐ (Check One.)
4. Country where Medical School located: U.S.A.
5. Date of Graduation: JUNE 1968
6. American Specialty Board Certified? ☐ (Check if yes.)
   Which Boards? ___
7. Principal Specialty(ies): GYN - FP
8. Principal work setting: PRIVATE OFFICE
9. Home address: ___
10. Principal business address: SAME
11. List all hospitals at which you have currently effective privileges: ___
12. List all hospitals at which you have held privileges in the past 20 years: ___
13. States other than Massachusetts in which you are presently licensed to practice: NY - CA - DC - KY - GA - FL - CT
14. List any other states where you were previously licensed to practice: ___

	YES	NO
15. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)?		
16. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?		
17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?		
18. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any time?		
19. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason?		
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22. Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23. Have you ever, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? If yes, which one(s)? ___		

25. I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: AMA PRA
26. I am an active ☒ inactive ☐ practitioner. (Check One.)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BACK) INCLUDING ATTACHED SHEETS IS TRUE.

PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BENEFICIARY MORE THAN THE MEDICARE REASONABLE CHARGE FOR MY SERVICES.

PURSUANT TO M.G.L. c. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. **PLEASE NOTE:** THIS APPLIES EVEN IF YOU RESIDE OUT-OF-STATE OR OUT OF THE COUNTRY.

SIGNATURE

DATE: 5 Aug 87

(See Reverse Side)

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration Renewal Application, Page 1 of 2

015972

Board Use Only:

Registration No.	Status	Fee	Renewal Date
		$150	

RECEIVED SEP 1989

M.R. Pr. Bk. Ch. D.E. Fl.

Important:
- *Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action.*
- *Print legibly or type your answers.*
- *Answer all non-optional questions (front and back of form) completely--***it is not adequate to state that the Board already has the information.**
- *Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.*
- *Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes.*
- *Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.*

1. a) Name (LAST:) ZUPNICK (FIRST:) GERALD (M.I.:)

1. b) Other Name(s), if any, that you were ever licensed under:

2. a) Address (Mailing):

2. b) Address (Home): SAME

2. c) Address (Business): SAME

2. d) Telephone (Business): 617 [illegible] Extension 2. e) Telephone (Home) *(Optional)*:

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

6. a) Medical School Code *(See Table 1)*: KY002 *If 99999, write* Name:

6. b) Year Graduated: 1968 6. c) Degree: M.D. X D.O.

6. d) Country: U.S. X Canada Code if Other *(See Table 2)*: *If 999, write* Name:

7. Work Setting *(Circle and Indicate Percent(%) of Practice Time)*:

10 Hospital	%	15 Private Office	100 %	20 Partnership/Group Practice	%
25 Clinic	%	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	%	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

8. Professional Activity *(Circle and Indicate Percent(%) of Professional Time)*:

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	100 %	
30 Administrative Activities	%	40 Medical Teaching	%	
50 Medical Research	%	99 Other	%	

8. b) Mass. Lic. Issue Date *(see your wall certificate)* (MO/DA/YR): 4/16/70

9. Specialty Code *(See Table 3)*: FP Percent of Practice Time: 55 % Specialty Code: GYN Percent of Practice Time: 45 %
If OS, specify:

10. a) Are you American Specialty Board Certified? (Y/N) N *10. b) If YES, circle which Board(s):*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	OG	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11. a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated; Percent of Practice Time at each. *(See Table 4.)*

Facility Code: ____ ____% Facility Code: ____ ____% Facility Code: ____ ____%
Facility Code: ____ ____% Facility Code: ____ ____% Facility Code: ____ ____%

If 999, write Name(s):

11. b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years. *(See Table 4.)*

Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____ Facility Code: ____

If 999, write Name(s):

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) ____ attached pages--is true.

Signature: (see reverse side) Date: 8/1/89

Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

Fill in name and number. **Physician Last Name:** ZUPNICK **Registration No.:** 32195

12. a) Other States where you are now licensed to practice (*Abbreviate*): NY CA FL KY GA DC

12. b) States where you previously were licensed to practice (*Abbreviate*): NY CA FL KY GA DC

13. I am applying to be registered with the following status: ACTIVE X INACTIVE___ *If ACTIVE, answer questions 14. a) through c). If INACTIVE, answer question 14. b) only.*

14. a) I have completed my C.M.E. requirements in the two years ending on the renewal date as follows: *(Fill in # of hours or type of residency, or check waiver.)*
Category I: 45 hrs., Category II: 90 hrs., (Risk-Management: 10 hrs.); Residency Program in:_____.
Waiver Requested___ (You must fill out a separate Waiver Form.)

14. b) My medical malpractice insurance is covered by INSURANCE CARRIER___ LETTER OF CREDIT___. *If applicable, check one and identify the name.*
Insurer:_____ Institution issuing Letter of Credit:_____
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE___ OTHERWISE EXEMPTED X *(State how)* NO DIRECT OR INDIRECT RESPONSIBILITY FOR PATIENT CARE IN MASSACHUSETTS

14. c) Percent of Practice Time in Massachusetts: 0 %

Questions 15 through 17 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached. **Yes** **No**

15. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?.....

16. Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?.....

17. Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?.....

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only. Check either YES or NO (not N/A) to each question. Provide details in the next section. **Yes** **No**

18. Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?.....

19. Have you withdrawn an application for a medical license or been denied a medical license for any reason?.....

20. Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?.....

21. *Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?*.....

22. Are you now, or have you been in the past, dependent upon alcohol or drugs?.....

23. Have you, for any reason, lost American Specialty Board Certification?.....

24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s):* ___ ___ ___ ___ ___ ___.....

Additional Information Related to Questions 18 through 24 *If you answered YES to any of Questions 18--24 provide the following information where applicable.*

Privileges to Prescribe Controlled Substances *Attach additional sheets (with same format) where necessary.*
Type of Restriction:_____ Date:___/___/___

Circumstances of restriction:_____

_____

_____

_____

Withdrawal or Denial of License *Attach additional sheets (with same format) where necessary.*
State:_____ Year:_____ Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated):_____

_____

_____

_____

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary.*
Treating Organization:_____ Telephone:(___ ___) ___ ___ ___-___ ___ ___ ___

Address:_____

Person Responsible for Treatment:_____

Type of Condition and Treatment:_____

_____

_____

_____

_____

Dates of Illness/Dependency:___/___/___ to :___/___/___ Dates of Treatment:___/___/___ to :___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary.*
Organization:_____

Date:___/___/___ Action:_____

Circumstances leading to loss of certification or denial of recertification:_____

_____

_____

_____

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

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.

- **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.: 32195 Renewal Date: 09/14/2003

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:

A) Mailing/Business Address:

3. GERALD ZUPNICK

~~B) Home Address:~~ OLD ADDRESS → NO LONGER USED

Home Phone:

Business Phone:

Please make corrections (print)

☐ Other Name(s) ☐ Name Change (enter name below)

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

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

Home Address: USE (A) MAILING
City/Town: _____ State: _____
Zip: _____ Country: ADDRESS
Home Telephone: (____) _____

PLEASE NOTE: Only one address can be a P.O. box. The mailing address cannot be a P.O. Box.

4. a) Date of Birth: b) Sex: M
c) SS#:

5. a) Name of Medical School: University of Louisville Sch.of Med.,Hlth.Sci.Ctr.
b) Year Graduated: 1968 c) Degree: M.D.

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

Code(s)	Hours per Week in Mass.	
FP	0	Family Practice
~~GYN~~	0	~~Gynecology~~

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

8. Drug License Numbers, if any:
a) Federal (DEA):
b) Massachusetts:

9. a) Other states where you are now licensed to practice (Abbr.) NY CA DC GA FL KY
b) States where you were previously licensed (Abbr.) NY CA DC GA FL KY

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 affiliations.

Facility Code: ___ ___ ___/___ (AP) _____ % Facility Code: ___ ___ ___/___ (AP) _____% Facility Code: ___ ___ ___/___ (AP) _____%
Facility Code: ___ ___ ___/___ (AP) _____ % Facility Code: ___ ___ ___/___ (AP) _____% Facility Code: ___ ___ ___/___ (AP) _____%
If 999, print name(s): _____

PRINT YOUR LAST NAME: ZUPNICK LICENSE NUMBER: 32195

11. My medical malpractice insurance is covered by ☒ Insurance Carrier ☐ Letter of Credit

Insurer's name. (Required): MMIP Policy dates: From: 9/1/03 To: 9/1/04

Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurance because I am: Check One: ☐ Not involved in direct/indirect patient care in Massachusetts ☐ A government employee.

☐ Otherwise exempt Please explain exemption: _____

12. What is your principal work setting? (See Table 4) 2 5 If you are affiliated with a healthcare facility or credentialed for the provision of patient care you must complete question #10 on page 1 and list your affiliations.

13. Care of patients in Massachusetts (see instruction booklet).

1) Average weekly hours involved in: A) inpatient care 0 hrs/wk B) outpatient care 0 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? _____%

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS (SEE INSTRUCTIONS)

Questions 14 through 22 refer to the period since you signed your last renewal application. Check either YES or NO to each question. Provide details on Form R for all YES answers (except question 22). Refer to instructions for additional information and definitions. ALL questions in this section must be answered. Do not answer NA or the form will be incomplete and delay your renewal.

	YES	NO
14. CLAIMS MADE (New or Pending): Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15. CLAIMS (Resolved): Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16. 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 been settled, adjudicated or otherwise resolved?		
17. Have you been charged with any criminal offense?		
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 or been denied a medical license for any reason?		
21. Has any professional liability insurance provider 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 professional liability insurance provider?		

22. CME CERTIFICATION: Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No

☐ CME Waiver. CME waiver form must be submitted at least 30 days prior to license expiration date.

CME EXEMPTION: Check one: ☐ Inactive status ☐ Residency/Fellowship training (See instructions).

See Instructions for CME waiver or exemptions. Do not submit documentation of your CMEs with application.

- Pursuant to G.L. c. 112, Sec 1A, I understand my obligations to report abuse or neglect of children under G.L. c. 119, Sec. 51A and the punishment for failure to comply.
- Pursuant to G.L. c. 112, Sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, 49A, I certify that I have complied with all laws of the Commonwealth related to the filing of Massachusetts state tax returns and payment of all Massachusetts state taxes; reporting of employees and contractors under G.L. c. 62E; and withholding and remitting child support pursuant to G.L. c. 119A. (See instructions).

I hereby certify under the penalties of perjury that all information on this Renewal Application, Part B and Form R is true.

Signature: _____ Date: 8/29/03

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

Board Regulations require that you notify the Board, in writing, of any change of address

MAKE A COPY OF YOUR APPLICATION AND ALL ATTACHMENTS BEFORE MAILING.

Commonwealth of Massachusetts Board of Registration in Medicine

Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

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
- **Remit $250.00 for renewal fee.**
- **Add late fee of $25.00, if necessary**
- **Return renewal application in GREEN envelope.**
- **Enclose check with coupon in BLUE envelope**

Registration No 32195 Renewal Date 09/14/1999 Current Status Active

RECEIVED OCT 18 1999 Board of Registration in Medicine

If you want to change your current status, please indicate below (Check one)

☐ Active ☐ Retiring (see instructions) ☐ Inactive (see below *) ☐ Do not wish to renew

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

3 A) Mailing/Business Address
GERALD ZUPNICK

B) Home Address

Home Phone
Business Phone

4 A) Date of Birth Sex M
B) SS#

5 A) Name of Medical School
University of Louisville Sch of Med ,Hlth.Sci Ctr

B) Year Graduated 1968 C) Degree M D

6 Specialty Code(s) (See Table 1)

Code(s)		Hours per Week in Mass
~~FP~~	0	~~Family Practice~~
GYN	0	Gynecology

Please make corrections (type or print)

Other Name(s) _____

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

Other Address _____
City/Town _____ State ____
Zip _____ Country _____

Home ( ) _____
Business ( ) _____

Date of Birth (M/D/Y) __/__/__ Sex ☐ M ☐ F
SS# ___-___-____

Full Name of Medical School _____

Year Graduated _____ Degree ☐ M D ☐ D O

Code(s)	Hours Per Week in Massachusetts
If OS, Print Specialty	

7 Current American Board of Medical Specialties Certification (See Table 2)
Code Code

Code _____ Code _____

8 Drug License Numbers, if any
A) Federal (DEA)
B) Massachusetts

Federal (DEA) _____
Mass _____

9 A) Other states where you are now licensed to practice
Abbr NY CA DC GA FL KY

B) States where you previously were licensed to practice
Abbr NY CA DC GA FL KY

Abbr ____ ____ ____ ____

Abbr ____ ____ ____ ____

*If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.

PRINT NAME AND NUMBER Last Name _____ Registration Number _____

10 Current health care facilities at which you 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.

Facility Code ___ ___/___ (AP) ____ % Facility Code ___ ___/___ (AP) ____% Facility Code ___ ___/___ (AP) ____%

Facility Code ___ ___/___ (AP) ____ % Facility Code ___ ___/___ (AP) ____% Facility Code ___ ___/___ (AP) ____%

If 999, print name(s) _____

11 My medical malpractice insurance is covered by a) ☒ Insurance Carrier b) ☐ Letter of Credit

Name of Insurer [illegible] Alternatively, indicate as follows

I am registering with Active status but I am not covered by medical malpractice insurance because I am (check one)

a) ☐ Not involved in direct/indirect patient care in Massachusetts b) ☐ Otherwise exempt

Please explain exemption _____

12 Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13 A What is your principal work setting? (See Table 4) ___ ___

B Care of patients in Massachusetts (see instruction booklet)

1) Average weekly hours involved in a) outpatient care ____ hrs/wk b) inpatient care ____ hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? ____%

PART A – QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS

Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed.

	YES	NO
14 **CLAIMS MADE** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15 **CLAIMS RESOLVED** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16 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 been settled, adjudicated or otherwise resolved?		
17 Have you been charged with any criminal offense other than a minor traffic violation?		
18 Have you been formally 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 surrendered to or suspended, revoked, denied or restricted by any state or federal agency?		
20 Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21 Has any professional liability insurance provider 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 professional liability insurance provider?		
22 **CME CERTIFICATION** Have you completed your CME requirements preceding your renewal date? ☒ Yes ☐ No		

☐ CME Waiver requested (CME waiver form due 30 days prior to date of license expiration) ☐ CME exemption

See Instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- Pursuant to G.L. c. 112, § 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare fee schedule amount.
- Pursuant to G.L. c. 62C, § 49A, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you live out-of-state or out of the United States.
- Pursuant to G.L. c. 112, § 1A, I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, § 51A.
- *I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form R is true*

Signature _____ Date ___/___/___

YOU MUST SIGN AND INCLUDE PART B, WITH YOUR RENEWAL APPLICATION

#15

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, MA 02111 (617) 727-3086, ext. 320

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
  The Board will charge a fee for each copy
  - **Remit $250.00 for renewal fee**
  - **Add late fee of $25.00, if necessary**
  - **Return renewal application in GREEN envelope**
  - **Enclose check with coupon in BLUE envelope.**

Registration No **32195** Renewal Date **09/14/97** SEP 1 3 1997

1 Activity Status (Check only one)
☒ Active ☐ Inactive *(see below) ☐ Retiring (see instructions) ☐ Do not wish to renew

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

3 A) Mailing/Business Address:

GERALD ZUPNICK, M.D.

B) Home Address:

Home Phone ( ) -
Business Phone **(516)883-2526**

4 A) Date of Birth C) Sex **M**
B) Lic Issue Date **04/16/70** D) SS#

5 A) Name of Medical School
University of Louisville Sch.of Med.,Hlth.Sci.Ctr.
B) Year Graduated **68** C) Degree **MD**

6 Specialty Code(s) (See Table 1)

Code(s)	Hours per Week in Mass	
FP	**0**	**Family Practice**
GYN	**0**	**Gynecology**

7 Current American Board of Medical Specialties Certification (See Table 2)
Code Code

8 Drug License Numbers, if any
A) Federal (DEA)
B) Massachusetts

9 A) Other states where you are now licensed to practice
Abbr **NY CA DC GA FL KY**
B) States where you previously were licensed to practice
Abbr **NY CA DC GA FL**

Corrections (type or print)

Other Name(s) _____

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

Other Address _____
City/Town _____ State _____
Zip _____ Country _____

Home ( ) _____
Business ( ) _____

Date of Birth (M/D/Y) __/__/__ Sex (M/F) _____
Lic Issue Date (M/D/Y) __/__/__ SS# _____

Full Name of Medical School
_____
_____

Year Graduated _____ Degree (MD/DO) _____

Code(s) Hours Per Week in Mass
___ ___ ___ _____
___ ___ ___ _____
If OS, Print Specialty _____

Code _____ Code _____

Federal (DEA) _____
Mass _____

Abbr ___ ___ ___ ___
Abbr NY ___ ___ ___

*If requesting Inactive status, you agree not to practice medicine, including writing prescriptions, in Massachusetts

PRINT NAME AND NUMBER: Last Name ZUPNICK Registration Number 32195

10 A Current health care facilities at which you 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)

Facility Code ____/__(AP) Facility Code ____/__(AP) Facility Code ____/__(AP)
Facility Code ____/__(AP) Facility Code ____/__(AP) Facility Code ____/__(AP)
If 999, print name(s) _____

B Additional health care facilities at which you previously held privileges or with which you were associated in the past two (2) years (See Table 3)

Facility Code ____ Facility Code ____ Facility Code ____ Facility Code ____ Facility Code ____
If 999, write Name(s) _____

11 My medical malpractice insurance is covered by a) X Insurance Carrier ____b) Letter of Credit

Name of Insurer MLMIC

Alternatively, indicate as follows I am registering with Active status but I am not covered by medical malpractice insurance because

I am (check one) a) X Not involved in direct/indirect patient care in Massachusetts b) ____ Otherwise exempt

Please explain exemption _____

12 Are you currently in a post-graduate training program in Mass as a resident or clinical fellow? (check one) ☐ Yes ☒ No

13 A What is your principal work setting? (See Table 4) 1 5

B Care of patients in Massachusetts (see instruction booklet) 0

1) Average weekly hours involved in a) outpatient care 0 hrs/wk b) inpatient care 0 hrs/wk

2) What is the approximate percentage of your patient care hours in primary care? 10 %

PART A

Questions 14 through 22 refer to the past two (2) years only Check either YES or NO (NOT N/A) to each question. Provide details on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional information and definitions.

IN THE PAST TWO (2) YEARS:

		YES	NO
14	**CLAIMS MADE:** Has any medical malpractice claim been made against you that has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?		
15	**CLAIMS RESOLVED:** Has any medical malpractice claim that has been made against you been settled, adjudicated, or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?		
16	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 been settled adjudicated or otherwise resolved?		
17	Have you been charged with any criminal offense, other than a minor traffic violation?		
18	Have you been formally charged with or disciplined for any violation of the rules by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?		
19	Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended revoked, denied or restricted by any state or federal agency?		
20	Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
21	Has any professional liability insurance provider 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 professional liability insurance provider?		
22	Have you completed your CME requirements preceding your renewal date (see instruction booklet)?		

☐ Waiver requested (waiver form due 30 days prior to date of license expiration) ☐ Training Program exemption

See Instructions for CME requirements Do not submit documentation of your CMEs with your renewal application

RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PART B MUST BE ANSWERED

Signature _____ Date 1/__/__

#15

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

Registration No	Status	Fee	Renewal Date	Late Fee
32195	ACTIVE	$250.00	09/14/93	$25.00

Mailing Address:
GERALD ZUPNICK, M.D.

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

Directions: **Staple check to bottom of form. Add late fee if necessary.**
- Questions 1-8 include information from Board files. Please correct as necessary in the boxes provided on the right hand side of the page
- Before proceeding, please read the instruction booklet Some questions are optional.
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes The Board will charge a fee for each copy it provides
- Enclose the $250 00 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

For Office Use Only
M.R. SEP 15 1993
Pr. SEP 15 1993
Bk/D.E. _____

Pre-Printed Information | **Corrections of Pre-Printed Information**

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

2. a) Address (Home).

b) Address (Business)

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

3. Date of Birth: Sex M
Lic Issue Date: 04/16/70 SS#:
Telephone Number:
Home Business
(516)883-2526

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

4 Name of Medical School:
University of Louisville Sch.of Med./Hlth.Sci.Ctr.
Year Graduated. 68 Degree: MD

Full Name of Medical School _____
Year Graduated _____ Degree (MD/DO) _____

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

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

Code	Hours per Week in Mass	
FP	0	Family Practice
GYN	0	Gynecology

Code	Hours per Week in Mass

If OS, print specialty _____

7 a) If you are currently American Specialty Board Certified, enter Codes (See Table 3)
Code. Code

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

Code _____ Code _____

Code _____ Code _____

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

Federal (DEA). _____
State (MA) _____

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

Staple Check Here

PRINT NAME AND NUMBER: Physician Last Name. ZUPNICK Registration Number: 32195

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

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

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

List Insurer: MED. MALPRAC. INS. ASS. 110 WILLIAM ST, NYC 10038

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am

(Check One): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE IN MASS.____ (ii) OTHERWISE EXEMPT: ____

(State how otherwise exempt): ____

12. Current Health Care Facility Affiliations Supply the codes from Table 4 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): ____

Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 4.)

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code. ___ ___ ___ Facility Code. ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): ____

13. Are you currently in a post-graduate training program in MA as a resident or clinical fellow? Yes____ No ✓ (Check one)

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

b) Care of patients in Massachusetts (MA) (See instruction booklet)

i) How many hours per typical week are you currently involved in *outpatient* care in MA? 0 hrs/wk in MA

ii) How many hours per typical week are you currently involved in *inpatient* care in MA? 0 hrs/wk in MA

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

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

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

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

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

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

Signature: ____ Date: 9/10/93

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1989-1991 Physician Registration/Renewal Application, Page 1 of 2

015972

Board Use Only			
Registration No	Status	Fee	Renewal Date
		$150	

RECEIVED SEP 1989

MR
Pr
Bk
Ch
D E
FI

Important

Read the accompanying instructions in their entirety before completing this form. Do not delegate this important task to an employee, as false statements on this form can result in disciplinary action
Print legibly or type your answers
*Answer all non-optional questions (front and back of form) completely--***it is not adequate to state that the Board already has the information**
Sign the renewal application at the bottom of page one and fill in the number of attached pages in the paragraph above the signature.
Make a copy of this form and all attachments for your own records--you must give hospitals and other health care facilities copies for credentialing purposes
Enclose the $150 renewal fee by means of a certified check, money order or personal check made payable to the Commonwealth of Massachusetts.

1 a) Name (LAST) ZUPNICK (FIRST) GERALD (MI)

1 b) Other Name(s), if any, that you were ever licensed under

2 a) Address (Mailing)

2 b) Address (Home) SAME

2 c) Address (Business) SAME

2 d) Telephone (Business) (516)883-2526 Extension 2 e) Telephone (Home) *(Optional)*

3 Date of Birth (MO/DA/YR) 4 Sex MALE X FEMALE 5 Social Security No *(Optional)*

6 a) Medical School Code *(See Table 1)* KY002 *If 99999, write* Name

6 b) Year Graduated 1968 6 c) Degree M D X D O

6 d) Country U S X Canada Code if Other *(See Table 2)* *If 999, write* Name

7 Work Setting *(Circle and indicate Percent(%) of Practice Time)*

10 Hospital	%	15 Private Office	100 %	20 Partnership/Group Practice	%
25 Clinic	%	30 Mental Health Center	%	35 Nursing Home	%
40 HMO Facility	%	45 Educational Institution	%	50 Medical Society	%
55 Government Facility	%	60 Plant/Commercial Setting	%	99 Other	%

8 Professional Activity *(Circle and indicate Percent(%) of Professional Time)*

10 Resident or Fellow	%	20 Practice Involving Direct Patient Care	100 %	8 b) Mass Lic Issue Date *(see your wall certificate)* (MO/DA/YR): 4/16/70	
30 Administrative Activities	%	40 Medical Teaching	%		
50 Medical Research	%	99 Other	%		

9 Specialty Code *(See Table 3)* FP Percent of Practice Time 55 % Specialty Code GYN Percent of Practice Time 45 %
If OS, specify

10 a) Are you American Specialty Board Certified? (Y/N) N *10 b) If YES, circle which Board(s)*

AI	Board of Allergy & Immunology	NM	Board of Nuclear Medicine	PS	Board of Plastic Surgery
A	Board of Anesthesiology	OG	Board of Obstetrics & Gynecology	PM	Board of Preventive Medicine
CRS	Board of Colon & Rectal Surgery	OP	Board of Ophthalmology	PN	Board of Psychiatry & Neurology
D	Board of Dermatology	OS	Board of Orthopedic Surgery	R	Board of Radiology
EM	Board of Emergency Medicine	OT	Board of Otolaryngology	S	Board of Surgery
FP	Board of Family Practice	PA	Board of Pathology	TS	Board of Thoracic Surgery
IM	Board of Internal Medicine	PE	Board of Pediatrics	U	Board of Urology
NS	Board of Neurological Surgery	PMR	Board of Physical Medicine & Rehabilitation		

11 a) Hospitals at which you have currently effective privileges and other Health Care Facilities with which you are associated, Percent of Practice Time at each *(See Table 4)*

Facility Code % Facility Code % Facility Code %
Facility Code % Facility Code % Facility Code %

If 999, write Name(s)

11 b) Additional Hospitals at which you previously held privileges and other Health Care Facilities with which you were associated in the past 10 years *(See Table 4)*

Facility Code Facility Code Facility Code Facility Code Facility Code

If 999, write Name(s)

* **I hereby certify that if requesting INACTIVE status, I will not practice medicine in Massachusetts.**

Pursuant to M.G.L. c475, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charge for my services.

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

I hereby certify under the penalties of perjury that all information on this form--front and back and (#) attached pages--is true.

Signature (see reverse side) Date 8/1/89

Fill in name and number **Physician Last Name:** ZUPNICK **Registration No.:** 32195

12 a) Other States where you are now licensed to practice *(Abbreviate)* NY CA FL KY GA DC

12 b) States where you previously were licensed to practice *(Abbreviate)* NY CA FL KY GA DC

13 I am applying to be registered with the following status ACTIVE X INACTIVE___ *If ACTIVE, answer questions 14. a) through c) If INACTIVE, answer question 14. b) only.*

14 a) I have completed my C M E requirements in the two years ending on the renewal date as follows. *(Fill in # of hours or type of residency, or check waiver.)*
Category I 45 hrs . Category II 90 hrs., (Risk-Management 10 hrs), Residency Program in _____,
Waiver Requested___ (You must fill out a separate Waiver Form)

14 b) My medical malpractice insurance is covered by INSURANCE CARRIER___ LETTER OF CREDIT___ *If applicable, check one and identify the name*
Insurer _____ Institution issuing Letter of Credit _____
Alternatively, indicate as follows. I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am *(Check one)*
NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE___ OTHERWISE EXEMPTED X *(State how)* NO DIRECT OR INDIRECT RESPONSIBILITY FOR PATIENT CARE IN MASSACHUSETTS

14 c) Percent of Practice Time in Massachusetts 0 %

Questions 15 through 17 refer to the past four years only Check either YES or NO (not N/A) to each question. Provide details on Form 15A, attached

	Yes	No
15 Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?		
16 Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?		
17 Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulations--*See Instructions*) been taken against you by any governmental authority hospital or other health care facility, or professional medical association (international, national, state or local)?		

If you answered "YES" to question 15, 16, or 17 provide details on Form 15A, attached.

****

Questions 18 through 24 refer to the past four years only Check either YES or NO (not N/A) to each question Provide details in the next section

	Yes	No
18 Has your privilege to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted, surrendered, or have you been called before or been warned by this state or any other jurisdiction including a federal agency?		
19 Have you withdrawn an application for a medical license or been denied a medical license for any reason?		
20 Have you had any mental illness which has impaired your ability to practice medicine or to function as a student of medicine?		
21 Have you had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?		
22 Are you now, or have you been in the past, dependent upon alcohol or drugs?		
23 Have you, for any reason, lost American Specialty Board Certification?		
24. Have you been denied recertification by one or more specialty boards? *If YES, list Board(s)* ___ ___ ___		

Additional Information Related to Questions 18 through 24 *If you answered YES to any of Questions 18--24 provide the following information where applicable.*

Privileges to Prescribe Controlled Substances *Attach additional sheets (with same format) where necessary.*
Type of Restriction _____ Date:___/___/___
Circumstances of restriction _____

Withdrawal or Denial of License *Attach additional sheets (with same format) where necessary*
State _____ Year _____ Circumstances under which license was withdrawn or denied (revoked, not renewed, or otherwise terminated) _____

Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency *Attach additional sheets (with same format) where necessary*
Treating Organization _____ Telephone (___) ___-____
Address _____
Person Responsible for Treatment _____
Type of Condition and Treatment _____
Dates of Illness/Dependency:___/___/___ to ___/___/___ Dates of Treatment:___/___/___ to :___/___/___

Specialty Certification *Attach additional sheets (with same format) where necessary*
Organization _____
Date.___/___/___ Action _____
Circumstances leading to loss of certification or denial of recertification: _____

BOARD OF REGISTRATION IN MEDICINE

BOSTON, MASSACHUSETTS

RENEWAL APPLICATION

SEE REVERSE SIDE

LICENSE NUMBER			PAY THIS AMOUNT	FEE			
CODE	TYPE	REGISTRATION NO.					
MD	1	52195	$100	100	09	14	87

GERALD ZUPNICK

Poor Original Copy

YOU MUST READ THE INSTRUCTIONS ENCLOSED WITH THIS FORM TO ANSWER QUESTIONS

1. Print Name: GERALD ZUPNICK

2. Medical School: UNIV. OF VERMONT

4. Country where Medical School located: U.S.A.

5. American Specialty Board Certified [x] (Check if yes)

6. Which Board(s):

7. Principal Specialty:

8. Home address:

11. List all hospitals at which you have staff privileges

12. List all hospitals at which you have had privileges in the past

13. States other than Massachusetts in which you are presently licensed

14. List any other states where you are or previously licensed

15. Has any medical malpractice claim been made against you

16. Have you at any time been a defendant in any criminal proceedings

17. Are any formal disciplinary charges pending or has any disciplinary action been taken against you by any licensing authority, by any hospital or health care facility, or by any professional medical association

18. Has your privilege to possess, dispense or prescribe controlled substances ... or have you been called before or warned by this Board or any other

19. Have you ever withdrawn an application for medical licensure

20. Have you ever had any mental illness which has impaired your ability to practice

21. Have you ever had a physical illness which has impaired your ability to practice

22. Are you now, or have you been in the past, dependent upon drugs or alcohol

23. Have you ever taken the examination for American Specialty Board Certification

24. Have you been denied board certification by one or more specialty boards? If yes, which board(s)

I have completed my CME requirements in the two years ...

I am an active [x] inactive [ ] non-resident (Check One)

I HEREBY CERTIFY UNDER THE PENALTIES OF PERJURY THAT ...

PURSUANT TO CHAPTER ...

PURSUANT TO M.G.L. ... I CERTIFY UNDER THE PENALTIES OF PERJURY ... RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

OARD OF REGISTRATION IN MEDICINE
ROOM 1507 — 100 CAMBRIDGE STREET
BOSTON, MASSACHUSETTS 02202
RENEWAL APPLICATION
1986-1988

IMPORTANT — READ, COMPLETE AND SIGN —

PURSUANT TO M G L c 62C § 49A I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW

SOC SEC NO OPTIONAL

YOU MUST SIGN BELOW

X _____
APP. CANT'S SIGNATURE

SEE REVERSE SIDE

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS ON THE REVERSE SIDE OF THIS APPLICATION (SEE THE ENCLOSED INSTRUCTIONS FOR DETAILS)

IF YOU ANSWERED "YES" TO ANY OF THESE QUESTIONS YOU MUST CHECK THIS BOX ☑

PLEASE USE THE ENCLOSED RETURN ENVELOPE

LICENSE NUMBER			PAY THIS AMOUNT	FEE	DATE TO BE RENEWED			LATE FEE
CODE	TYPE	REGISTRATION NO			MO	DA	YR	
MD		32195	100.00	100.00	01	15	86	

NOTE! THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A $100 PAYMENT A CERTIFIED CHECK OR MONEY ORDER IS PREFERRED PERSONAL CHECKS ARE ACCEPTABLE

PAYABLE TO
COMMONWEALTH OF MASSACHUSETTS
P O BOX 6
BOSTON MASSACHUSETTS 02297

DO NOT FOLD OR STAPLE THIS FORM

GERALD ZUPNICK

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

POOR ORIGINAL COPY

3500600321950 011586 10000000084

34

Print Name GERALD ZUPNICK M D Date of Birth

Medical School UNIV OF LOUISVILLE Date of Graduation 6/68

You must read the instructions enclosed with this form to answer questions 1-12

1 Principal Specialty(ies) FP-GYN

2 Principal work setting PRIVATE OFFICE

3 Home address SAME AS FRONT

4 Principal business address SAME AS FRONT

5 List all hospitals at which you have currently effective privileges

6 States other than Massachusetts in which you are licensed to practice N Y CALIF KY. GA.

	YES	NO
7 Have you been a defendant in any malpractice suit commenced since 10/1/83?		
8 Have you been a defendant in any criminal proceeding other than minor traffic offenses commenced since 10/1/83?		
9 Has any disciplinary action been taken against you in the last ten years, by any governmental authority, by any hospital or health care facility or by any professional medical association (international, national, state or local)?		
10 Has your privilege to possess, dispense or prescribe controlled substances ever been suspended or revoked in this state or any other?		

11 I have completed my C M E requirements between 1/15/84 & 1/15/86 as follows PHYSICIAN'S REC AWARD OF AMA 1983

12 I am an active ✓ inactive _____ practitioner (Check one)

I HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE

SIGNATURE

(YOU MUST ALSO SIGN THE FRONT OF THIS CARD)

Massachusetts Physician Renewal Application

Physician Name: GERALD ZUPNICK **License No.: 32195**

08/30/05 SU 72

PART A

1) Current Status: Active **Renewal Due Date:** 08/17/2005 **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

AUG 2 9 2005

BOARD OF REGISTRATION IN MEDICINE

☐ *Check here to change this address*

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

29-28 41st Avenue
Long Island City, NY 11101

Phone:

☒ *Check here to change this address*

Business Address: 26 BLEECKER STREET

City/Town: NEW YORK State: NY

Zip: 10012 Country: USA

Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

5) Specialties *(See Renewal Instructions, page 4.)*	**Delete?**	**Additional specialties:**
Family Practice	☐	
Gynecology	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: GERALD ZUPNICK **License No.: 32195**

(See Renewal Instructions, page 4.)	*Please make corrections as necessary*
7) Drug License Numbers, if any:	**8a) Other states where you are now licensed to practice (Abbr.)**
a) Massachusetts:	NY CA DC GA FL KY ____ ____
b) Federal (DEA):	**8b) States where you were previously licensed (Abbr.)**
c) Federal (DEA) XS:	NY CA DC GA FL KY ____ ____

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

Principal Work Setting: Clinic Change to: _____

Please enter the *approximate* number of work hours at your principal work setting: 24

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 ☒ Please enter the *approximate* number of work hours for each Health Care Facility below:

Health Care Facility *(See Renewal Instructions, page 4.)*	Delete?	Staff Category Current	Staff Category Change	*Approximate* # Hours per Week
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			
	☐			

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

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

b) outpatient care 0 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)***

Current Insurance Carrier: Change to: _____

Policy dates: From ___/___/____ To ___/___/____ *(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: GERALD ZUPNICK **License No.: 32195**

13) Do you perform any surgery in your office? *(See Renewal Instructions, page 5.)* If Yes, please complete Form PCA-O "Office Based Surgery"	**Yes**	**No**

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? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver?

☐ Check to request CME Waiver. A CME waiver request form must be submitted at least 30 days prior to your license expiration date. *(See Renewal Instructions, page 8.)*

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: GERALD ZUPNICK **License No.: 32195**

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: 8/14/05

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

08/30/05 15:

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.:** 32195

PART A

1) **Current Status:** Active **Renewal Due Date:** 08/17/2007 **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*

RECEIVED
AUG 17 2007
Board of Registration in Medicine

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

26 Bleecker Street
New York, NY 10012

Phone:

☑ *Check here to change this address*

3) E-mail Address: _____

4) Fax Number: _____

Please make corrections (print)

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

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:**
Family Practice	☐	
Gynecology	☐	
	☐	

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

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

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

(See Renewal Instructions, page 4.)

7) Drug License Numbers **Corrections:**

a) Massachusetts: _____

b) Federal (DEA): . _____

c) Federal (DEA) XS: _____

Please make corrections as necessary

8) Other states where you are now licensed to practice

NY CA DC GA FL KY ____

9) States where you were previously licensed

NY CA DC GA FL KY ____

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
			☐
			☐
			☐
			☐
			☐

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

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

b) outpatient care 0 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)*** I HAVE NO IDEA WHAT CRICO IS!

Current Insurance Carrier: CRICO → 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. N/A

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

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

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

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

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: 8/9/07

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: Gerald Zupnick, M.D. **License No.: 32195**

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:	☐☐☐☐☐☐☐☐☐☐	_____
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): _____ Country of Birth (if outside the US): _____

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: ☐ **I authorize** ☒ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

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

Signature: _____ Date: 8/9/07

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

PART A

1) Current Status: Active **Renewal Due Date:** 08/17/2007 **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.

RECEIVED
AUG 29 2007
Board of Registration in Medicine

2a) MAILING ADDRESS

☐ *Check here to change this address*

RECEIVED
AUG 17 2007
Board of Registration in Medicine

2b) HOME ADDRESS

Phone:

☐ *Check here to change this address*

2c) BUSINESS ADDRESS

26 Bleecker Street
New York, NY 10012

Phone:

☒ *Check here to change this address*

Please make corrections (print)

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: _____
City/Tov... _____ State _____
Zip: _____ Country: _____
Business Telephone: (___) _____

Business address cannot be a Post Office Box

3) E-mail Address: _____

4) Fax Number: _____

Correct your E-mail and Fax Number below:

_____

_____

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

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

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

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

(See Renewal Instructions, page 4.)		*Please make corrections as necessary*
7) Drug License Numbers	**Corrections:**	**8) Other states where you are now licensed to practice**
a) Massachusetts:		NY CA DC GA FL KY ____
b) Federal (DEA):		**9) States where you were previously licensed**
c) Federal (DEA) XS:		NY CA DC GA FL KY ____

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

List the names of all work sites in Massachusetts *(See above and description on page 4.)*	Location (City or Town)	State	Delete?
			☐
			☐
			☐
			☐
			☐

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

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

b) outpatient care 0 hrs/wk Change to: _____ hrs/wk

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

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

☐ **Insurance Carrier** ***(complete below)*** I HAVE NO IDEA WHAT CRICO IS!

Current Insurance Carrier: CRICO → 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.

8.26.07

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

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

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

	YES	NO
14) CLAIMS MADE a) **NEW**: Have you received notification of a claim, whether or not a lawsuit was filed on that claim, or has any medical malpractice claim been made against you **during this time period**? (see above). b) **PENDING:** Are there any unresolved malpractice claims **against you today**, i.e., any claims that have not been finally settled or finally adjudicated?		
15) CLAIMS CLOSED Has any medical malpractice claim against you (whether or not a lawsuit was filed on that claim) been resolved, settled, or adjudicated during this time period?		
16) OTHER CIVIL LAWSUITS Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine. a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period? b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this time period?		
17) CRIMINAL CHARGES a) Have you been charged with any criminal offense during this time period? b) Have any criminal offenses/charges against you been resolved during this time period? c) Are there any criminal charges pending against you today? d) Are any Applications for Issuance of Process pending against you?		
18) INVESTIGATIONS AND DISCIPLINARY ACTIONS a) Have you withdrawn an application to any governmental authority, health care facility, group practice, employer or professional association? b) Have you ever taken a leave of absence from any health care facility, group practice or employer? c) Have you been the subject of an investigation by any governmental authority, health care facility, group practice, employer or professional association? d) Have you been the subject of a disciplinary action taken by any governmental authority, health care facility, group practice, employer or professional association?		
19) Have your privileges to possess, dispense or prescribe controlled substances been suspended, revoked, denied, restricted by, or surrendered to any state or federal agency?		
20) Have you withdrawn an application for a medical license, allowed a license application to become obsolete or have you been denied a medical license for any reason?		
21) Has any medical liability insurance carrier restricted, limited, terminated, imposed a surcharge or co-payment, or placed any condition related to professional competency or conduct on your coverage, or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a medical liability insurance carrier?		

22) CME CERTIFICATION:

a) Have you completed your CME requirements preceding your renewal date? ☒ **Yes** ☐ **No**

b) If no, are you requesting a CME waiver? ☐ **Yes** ☐ **No**

A CME waiver request form must be submitted at least 30 days prior to your license expiration date.

c) If you are exempt from CME requirements, check reason for exemption. *(See Renewal Instructions, page 8.)*

CME EXEMPTION: (check one) ☐ Inactive Status ☐ Residency/Fellowship training

Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

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.

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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: 8/7/07

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Massachusetts Physician Renewal Application

Physician Name: Gerald Zupnick, M.D. **License No.: 32195**

NATIONAL PROVIDER IDENTIFIER (NPI)

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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:	☐☐☐☐☐☐☐☐☐☐	_____
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): _____ Country of Birth (if outside the US): _____

Gender: ☐ Male ☐ Female

Penalties for Falsifying Information on the National Provider Identifier Application

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

Authorization for NPI Dissemination

Check one box: ☐ **I authorize** ☒ **I do not authorize the Board of Registration in Medicine to provide my NPI number to any authorized hospital, health plan, or health organization.**

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

Signature: _____ Date: 8/9/07