

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.

	_				• 1	LUNUILU UULY
1. Current Status:	Active	Registration	No.32195	Ren	ewal Date: 09/14	· ·
If you want to cha	nge your curr	ent status, please check <u>or</u>	<u>re</u> of the fol	llowing boxes to indica	ite your <u>new</u> status	: (Check only one)
☐ Active	Retiring	(see instructions)	nactiv	e (see instructions)	Do not v	vish to renew
2. Other Name(s),	if any, under	which you were licensed:		Please make correcti	ons (type or print))
3. A) Mailing/Bu	siness Addre			Other, Name(s):		
GERALD			Tan	Maring Address: Cryfrowr Zip:	Country:	State
		BOARD OF RI	GISTRATIO			
B) Home Addi	ress:			City/Town:		State:
				Zip:Business Telephone:	Country:	
				Home Address: \(\) City/Town:		State:
Home Phone:				Zip:	Country:	
Business Phone:				PLEASE NOTE: No	P.O. Box addressiness addresses.	
4. a) Date of Birth:		b) Sex: M		rent American Board o Code:	f Medical Special Code:	ties Certification (See Table 2
c) SS#:						
5. a) Name of Medi	cal School:		a) '	ig License Numbers, if Federal (DEA):	any:	
University o	f Louisville S	ch of Med. Elith Sci.Ctr.	b)	Massachusetts:		
b) Year Graduate	d: 1968	ch.of Med., HIth. Sci. Ctr. c) Degree: M.D.	9. a) (Other states where you	are now licensed t LDC GA FL KY	• '
6. Specialty Code(s) Code(s) Ho	(See Table 1) ours per Week		ь) S	States where you were p		
FP 0 GYN 0	Family Pra Gynecolog		יאר	Y CA DC GATE RY		
the codes from [re facilities at able 3 and pl	which you have complete ace a check mark next to t approximate percentage of	those health	care facilities where y	ou have admitting	privileges (AP).
Facility Code: Facility Code: [1 999 print name(s):	/ (AP) _ / (AP) _	% Facility Code: % Facility Code:	/	(AP)% Facility (AP)% Facility	Code:/_ Code:/_	(AP)% (AP)%

PRINT '	YOUR LAST NAME: _	ZUPNICK		LICENSE NUMBER:	<u> </u>
11. My m	edical malpractice insura	ince is covered by a) <table-cell> Insi</table-cell>	rance Carrier	b) Letter of Credit	•
	of Insurer: MMIA			Alternatively, indicate as a	follows:
I am regis	tering with Active status	but I am not covered by med	ical malpractice	insurance because I am (chec	k one)
a) 🔲 N	ot involved in direct/indi	rect patient care in Massachu	setts b) 🔲 O	therwise exempt	
Please ex	olain exemption:				
12. Are ye	ou currently in a post-gra	duate training program in Ma	ssachusetts as a	resident or clinical fellow? (c	heck one) 🗌 Yes 💢 No
13. A. W	hat is your principal wor	k setting? (See Table 4) 🔼	5		
		nusetts (see instruction bookle			
		volved in: a) outpatie			hrs/wk
		percentage of your patient ca			
PART A	- QUESTIONS RI	EFER ONLY TO THE	PAST TWO	(2) YEARS	
Ouestions	14 through 22 refer to	the past two (2) years only.	Check either \	(ES or NO (NOT N/A) to ea	ch question. Provide
dataile an	Form D for all VES an	swers except for question 22 L questions, or this form w	. Refer to the i	nstruction booklet for addit	ional information and
definition	i. You must answer Al	L questions, or this form w	III DE LECTRI DELL F	o you and your memse tene	
		سفت فسادد دادین بیست		ر برون می این در ای	YES NO
settle	d or adjudicated, whether	edical malpractice claim beer or not a lawsuit was filed in	relation to the cla	aim?	
15. <u>CLAI</u> adjudi	MS RESOLVED: Ha cated, or otherwise resol	s any medical malpractice cla ved, whether or not a lawsuit	im that has been was filed in relat	made against you been settle tion to the claim?	d,
or you	ny lawsuit, other than a n ir professional conduct in vise resolved?	nedical malpractice suit, which the practice of medicine, bec	h is related to yo n filed against y	our competency to practice mo ou or been settled, adjudicate	edicine, d or
		ny criminal offense, other than			}
18. Have	you been charged with or evernmental authority, he	disciplined for any violation talk care facility, group pract	of laws, rules, b ice or profession	y-laws or standards of practical society or association?	e of
19. Has ye	our privilege to possess, ted by, or surrendered to	dispense or prescribe controlle any state or federal agency?	ed substances be	en suspended, revoked, denie	d,
20. Have	you withdrawn an applic	ation for a medical license or	been denied a m	edical license for any reason?	,
21. Has as	ny professional liability i	nsurance provider restricted, l	imited, terminate	ed, imposed a surcharge or	
you vo	ment, or placed any con bluntarily restricted, limit sional liability insurance	dition related to professional or ted or terminated your insurant provider?	competency or conce coverage in re	onduct on your coverage or he esponse to an inquiry by a	ave
22. <u>CME</u>	CERTIFICATION: H	ave you completed your CME	requirements pr	receding your renewal date?	Yes 🗌 No
		CME waiver form due 30 days			CME exemption
See Instru	ctions for CME require	ments. Do not submit docu	mentation.of.yo	our CMEs with your renewa	ıl application.
		t charge to or collect from a Mo			
Pursuant to Massachus	G.L. c. 62C, § 49A, to the	e best of my knowledge and bel quired under law. <u>NOTE</u> : Tbi	ief, I bave filed al s applies even if y	l Massachusetts state tax retur ou reside out-of-state or out of	ns and paid all the United States.
	ant to G.L c. 62C, § 47A olding and remitting Chi	, to the best of my knowledge Id Support.	and belief, I an	n in compliance with M.G.H.	C. 119A relating to
	0	 vill fulfill my obligation to repor	t abuse or neglect	of children as required by G.L.	c. 119, § 51A.
		ulties of perjury that all the in			
			-		
Signature:		- W		Da	ite: 8 /19/01
	11				

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 res • Copy this form and all attachments for your own records; you will i	ad the instruction booklet.
* Add late lee of \$25.00, if necessary.	999Return renewal application in GREEN envelope • Enclose check with coupon in BLUE envelope
Registration No.: 32195 Renewal Date: 09/14/1996	Medicine Current Status: Adie ECEIVED
If you want to change your current status, please indicate below: (Ch	neck one).
	ve (see below *) Do not wish to renew
2. Other Name(s), if any, under which you were licensed:	Please make corrections (type or print) Soard of Hegistration in Medicine Other Name(s):
3. A) Mailing/Business Address: GERALD ZUPNICK	Mailing Address: City/Town: State: Zip: Country: S. A.
B) Home Address:	Other Address: City/Town: Zip: Country:
Home Phone:	Home: (
Business Phone:	Business:
4. A) Date of Birth: Sex: M	Date of Birth: (M/D/Y): _ / _ / Sex : _ M
B) SS#: 5. A) Name of Medical School: University of Louisville Sch.of Med., Hith. Sci. Ctr.	Full Name of Medical School:
B) Year Graduated: 1968 C) Degree: M.D.	Year Graduated: Degree: M.D. D.O.
6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass. Family Francisce	Code(s) Hours Per Week in Massachusetts
GYN 0 Gynecology	If OS, Print Specialty:
7. Current American Board of Medical Specialties Certification (See Tode: Code:	Table 2) Code:
8. Drug License Numbers, if any:A) Federal (DEA):B) Massachusetts:	Federal (DEA): Mass:
A) Other states where you are now licensed to practice Abbr: NY CA DC GA FL KY	Abbr:
B) States where you previously were licensed to practice Abbr: NY CA DC GA FL KY	Abbr:
*If requesting <u>Inactive</u> status, you agree not to practice medicine, i	including writing prescriptions, in Massachusetts.
4	
Signature:	Date: 9 /5 / 99
COPY ALL PAGES OF VOUR RENEWA	AL APPLICATION BEFORE MAILING

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

> AS A REGISTERED PHYSICIAN

> > REGISTRATION NO.

32195

LICENSE NUMBER

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/ A-wo-APPLICANT'S SIGNATURE DATE TO BE RENEWED PAY THIS FFF LATE FEE MO DA YH 15 84 100.00 01 100.00

MY SIGNATURE ON THIS KENEWAL 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

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

DO NOT WRITE BELOW THIS LINE

PLEASE PRINT ANY NAME OR ADDRESS CHANGES BELOW

T FOLD OR

CODE

MD

GERALD ZUPNICK

TYPE

1. Principal Specialty(ies): * 1 5 1 0	2. Principal work setting: * 3 1
3. Home Address:	4. Primary work address: 31 FULTON AV
	HE MPS TEAD, 19.4. 11550
5. States other than Massachusetts in which you are licensed to	practice: NY CA KY FLA
6. Has a judgement been returned against you in a malpractice suit s	fnce 1/15/82?
7. Have you ever been convicted of any criminal offense other than m	inor traffic offenses?
8. Has any disciplinary action been taken against you in this state or	
9. Has your privilege to possess, dispense or prescribe controlled sub: in this state or any other?	tances ever been suspended or revoked
10. I have completed my C.M.F. requirements between 1/15/82 & 1/15.	/84 as follows:* [O] [S]
EHEREBY CHATIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE IN	FORMATION IS TRUE.
*SEL CODE SHEET	(YOU MUST) ALSO SIGN THE FRONT OF THE 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.

REQUIRED G	IDER LAW.	
SOC SEC NO. OPTRONAL	U MUST SIGN BELOW	_]
·	APPLEANED SEGNATURE	
7.115	1	7

SOC SEC NO., OPTRINA		OU MUST SIGN BELOW	
· -	41	APPLICANTS DIGNASTIRE	
THIS	-	DATE TO DE DENEMED	

LICENSE NUMBER		PAY THIS	FEE	DATE TO BE RENEWED			LATE FEE	
CODE	1 Y £16	HEGISTRA HON NO	AMOUNT		MO	DA	YA	27.11271211
MD D		321 95	100.00	100.00	01	15	86	
				0. 5.05 00	****			DUEDO

CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

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 OUFS-TIONS, YOU MUST CHECK THIS BOX:

PLEASE USE THE ENCLOSED RETURN ENVELOPE

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



3500600321950 011586 10000000

PAYABLE TO:

COMMONWEALTH OF MASSACHUSETTS

P.O. BOX 6

BOSTON, MASSACHUSETTS 02297

GERALD ZUPNICK

Print Name: GER-ALD ZUPNICH M.D	Date of Birth.
Medical School: UNIN. OF LOUISMILE Date of C You must read the instructions enclosed with this form to answer questions 1-12.	Graduation: b / 6 8
1. Principal Specialty(ies): TP-GYN	2. Principal work setting PRNATE OFFICE
3. Home address: SAME AS FRONT	4. Principal business address: SAME AS FRONT
3, Home address:	
5. List all hospitals at which you have currently effective privileges:	N.Y. CALIF. KY. GA.
6. States other man massachisetts in which you are meaned to practice.	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 off	olfenses commenced since 10/1/83?
Has any disciplinary action been taken against you in the last len years, by any go professional medical association (international, national, state or local)?	
10. Has your privilege to possess, dispense or prescribe controlled substances ever be	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: 12. I am an active	111

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	
Malling Address:	Address (Mailing):
GERALD ZUPNICK, M.D.	Ch. Paris
	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 a 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 - credentialing and other purposes. The Board will charge a fee for each cop See instructions on detachable coupon at bottom of this page. 	
Pre-Printed Information	Corrections of Pre-Printed Information
1. Other name(s), if any, under which you were licensed:	
	Name:
2. Home Address:	Address:
	City/Town: Zip:
•	Country:
3. Date of Birth: Sex: M	Date of Birth (M/D/Y): Sex (M/F):
Lic. Issue Date: 04/16/70 SS#:	Lic. Issue Date (M/D/Y):/ SS#:
04/16/70	Ducingge ()
Home Phone Business Phone	Home: () Business: ()
.6) 883-2526	Full Name of Medical School:
4. Name of Medical School:	
University of Louisville Sch.of	
Med., Hlth.Sci.Ctr.	Year Graduated: Degree (MD/DO):
Year Graduated: 68 Degree: MD	
5. a) Other states where you are now licensed to practice (Abbr): 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.	Code Hours per Week in Mass.
FP 0 Family Practice GYN 0 Gynecology	If OS, print specialty:
7. If you are currently American Specialty Board certified, enter codes: (5	See Table 2)
Code: Code:	Code: Code:
8. Drug license number(s), if any:	Padent (DDA).
a) Federal (DEA) b) Massachusetts	Federal (DEA): Mass:
oj masaciustus	\$7 \$ Med 19,
9. Activity Status: I am applying to be registered with the following state	us: ACTIVE X INACTIVE
· I hereby certify that if requesting Inactive status, I will not practice	

PRINT NAME AND NUMBER: Physician Last Name: 2010 Registration Number:	32195
10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Su codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP). Facility Code:/	pply the
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 (See Table 3) Facility Code: Facility	•
11. My medical malpractice insurance is covered by (a) Insurance Carrier (b) Letter of Credit If applicable, ch	eck one. YC 1001b
Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance be (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: (ii) Otherwise exempt: State how otherwise exempt:	cause I am
12. Are you currently in a post-graduate training program in Mass, as a resident or clinical fellow? Yes No _X_ (Ch	eck one)
13. a) What is your principal work setting? (See Table 4)	
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? ii) How many hours per typical week are you currently involved in inpatient care in Mass? c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.)	
Questions 14 through 24 refer to the past two years only. Check either YES or NO (NOT N/A) to each question. Provide de Forms R-1 and R-2 for all YES answers. Refer to the instruction booklet for additional information and definitions.	stails on
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?	
Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?	
25. I have completed my CME requirements in the two years preceding my renewal date: Yes 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 verification. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.	vill be
• Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reason	table 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 knowl I have flied all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: Ti	
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 a G.L. c. 119, sec. 51A.	required by
 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	<u> 715</u>

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 Fe 32195 ACTIVE \$250.00 09/14/93 \$25.0	['0'	rrection of Mailing Address:	
Mailing Address:	Address (Mailing):		
GERALD ZUPNICK, M.D.	m: m		
	City/Town:		
	Country Code (Sec Tabl	e 1):	
 Directions: Staple check to bottom of form. Add late fee if necessar Questions 1-8 include information from Board files. Please correct as a provided on the right hand side of the page. Before proceeding, please read the instruction booklet. Some questions Make a copy of this form and all attachments for your own records for credentialing and other purposes. The Board will charge a fee for a Enclose the \$250.00 renewal fee by means of a certified check, money a payable to the Commonwealth of Massachusetts. 	are optional. you will need copies each copy it provides.	For Office Use Only M.R. SEP 1 5 1993 SEP 1 5 1993 Pr	
Pre-Printed Information	Correction	s of Pre-Printed Information	
1. Other name(s), if any, under which you were licensed:			
•			
2. a) Address (Home):			
	State:	Zip:	
	Country Code:	If 999 print Country:	
h) Address (Dustingss):	Address (Business):		
b) Address (Business):	City/Town: If 999 print Country:		
	Country Code:	H 999 print Country.	
3. Date of Birth: Lic. Issue Date: 04/16/70 SS#: Telephone Number: Home Pusiness (510) 883-2526 3. Name of Medical School:	Lic. Issue Date (M/D/Y): Telephone Number: Home: ()	Sex (M/F): SS#: Business: ()	
University of Louisville Sch.of	Vear Graduated:	Degree (MD/DO):	
Year Graduated: 6.5 Degree: MD	Tom Gradaton.	Degrae (ND/DO).	
5. a) Other states where you are now licensed to practice (Abbr): il Y b) States where you previously were licensed to practice (Abbr): il Y	CA DC GA FL — CA DC GA FL —		
	Code	Hours per Week in Mass.	
6. Specialty Code(s) (See Table 2):			
Code Hours per Week in Mass.	If OS, print specialty:		
FP O Family Practice			
.SYN U Gynecology	(O / D-1-1- O)		
 a) If you are currently American Specialty Board Certified, enter Codes Code: Code: 	(See Table 3)	Code:	
b) If you previously were American Specialty Board certified, but are n	o longer,		
please enter codes of prior certification: (See Table 3)	i	Code: Code:	
Code: Code:	<u> </u>		
3. Drug License Number(s), if any: a) Federal (DEA)	İ	Federal (DEA):	
b) State (MA)	L,	State (MA):	
 I have completed my CME requirements in the two years preceding my You must fill out a separate Waiver Form. The waiver must be granted 	renewal date: Yes	No, waiver requested	
CME requirements. Do not submit documentation of your CMEs with		Staple Check Here	

PRINT	NAME AND NUMBER:	Physician Last Name: _	ZUPNICK	Registration Number	32195
10. Activ	ty Status: I am applying to be regis		/		•
• I her	eby certify that if requesting Inact	ive status, I will not practi	ce medicine, including w	clive riting prescriptions in Ma	seeochmeatte
	edical malpractice insurance is cover		•		
	List Insurer: MED. MALI	early (a) insurance (ARRIER or (b) LET	TER OF CREDIT If a	pplicable, check one
Alternative	ery, indicate as follows: I am registe	ring with ACTIVE status, b	out I am not covered by me	dical malpractice insurance	hecause I am
(Check O	ne): (i) NOT INVOLVED IN DIRE (State how otherwise exempt):	CT/INDIRECT PATIENT (CARE IN MASS: (ii) OTHERWISE EXEMPI	<u> </u>
	at Health Care Facility Affiliations. Sing privileges (AP). ty Code: / (AP)	Supply the codes from Table	e 4 and place a check mark	next to those facilities whe	•
Facili	ty Code: / (AP)	Facility Code:	/(AP) Fac	ility Code:	— (AP)
If 999 , pr	int name(s):				·
Facility C	al hospitals at which you previously Fable 4.) ode: Facility Code: rite name(s):	Facility Code	: Facility C		
	ou currently in a post-graduate training			Ves No / 10	hock one)
	hat is your principal work setting? (110	nock one)
b) Ca i)	re of patients in Massachusetts (MA) How many hours per typical week a How many hours per typical week a	(See instruction booklet.) we you currently involved in	n outpatient care in MA? _ n inpatient care in MA? _	hrs/wk in MA	
Quest	ions 15 through 23 refer to the past de details on Porm 15A for all YES a	Wo years only. Check eith	er VES or NO (NOT N/A)	\	
	PAST TWO YEARS:				
15. Has any	medical malpractice claim been made	le sosinst von whether or n	ot a lavemit was filed in	Andrea and a to a	YES NO
	on been charged with any criminal of				
17. Have yo	ou formally been charged with or disc mental authority, health care facility,	iplined for any violation of	the rules by-laws or stand	lards of massion of	
18. Has you	r privilege to possess, dispense or projected by any state or federal agency?	scribe controlled substance	s heen surrandered to or a	tenended servelsed demiss	
19. Have yo	u withdrawn an application for a med	lical license or been denied	a medical license for any	esson?	
	u had any mental iliness which has in				
	u had an organic illness which has in				
22. Are you	now, or have you been in the past two	o years, dependent upon alc	ohol or drugs?	as a standing of mexicine?	
23. Has any	professional liability insurance provi	der restricted, limited, termi	nated or imposed a surcha	rge on your coverage?	
• Pursue	nt to G.L. c. 112, sec. 2, I will not ch	narge to or collect from a ?	Medicare beneficiary mor	re than the Medicare reas	onable charges.
Pursuan filed all Mass	t to G.L. c. 62C, sec. 49A, I hereby achusetts state tax returns and pak state or out of the country.	certify under the negative	enfroring that to the		
• I hereby	certify that I will fulfill my obligat	ion to report abuse or neg	lect of children pursuant	to G.L. c. 119, sec. 51A,	
• I hereby	certify under the penalties of perju	ury that all information or	this form and Form 15	A is true.	
	\ \	L.			
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	For Office Use Only				
<u>52195 ACTIVE \$150 09/14/91</u> Dr. GERALD ZUPNICK	M.R				
	Bk				
	D.E. ENTERED SEP 1970				
Directions:	AND SEP THE				
 Cluestions 1-7 include information from Board tiles. Please correct Before proceeding, please read the instruction booklet. Answer all non-optional questions completely. (The instruction specifies) Make a copy of this form and all attachments for your own records—) \$3.00 plus postage for each copy furnished. 					
am applying to be registered with the following status: Active I hereby certify that if requesting inactive status, I will no	or practice medicine in Massachusetts.				
Pre-Printed Information	Corrections of Pre-Printed Information				
. Other Name(s), if any, under which you were licensed:	Name:				
t. a) Address (Home):	Address:				
**	City/Town				
	State: Zip:				
. b) Address (Business):	Country Code: (If 999 write Country):				
The second secon	Address:				
	State: Zip:				
	Country Code: (if 999, write Country):				
. Date of Birth; Sex; M	Date of Birth (M/D/Y):/ Sex (M/F):				
Lic. Issue Date 04/16/70 SSN#:	Lic. Issue Date(M/D/Y): / / SSN #:				
Telephone Number:					
Home Business (516)863-2526	Home: () Business: ()				
. Medical School CodeK Y 0 0 2 Year Graduatedo 8 Degree	: MD School Code: Year Graduated: Degree (MD/DO):				
Name of School:	If 9999, write School:				
University of Louisville Sch.of Me	ed./Hith.Sci.Ctr.				
a) Other States where you are now licensed to practice (Abbr)N Y b) States where you previously were licensed to practice (Abbr)S Y					
Specialty Code(s) (See Table 3):					
Code Hours per Week in Mass.	Code Hours per Week in Mass.				
<pre>FP</pre>	AND SECURITY AND SECURITY AND SECURITY AND SECURITY SECUR				
din o dynecotogy	If O9, write specialty:				
a) Are you American Specialty Board Certified? (Y/N)N 7.b) If	YES, Enter Codes:				
Cade:	Code:				
Code:	Code:				
Drug License Number(s) (if any) [optional]; a) Federal (DEA)					
I have completed my C.M.E. requirements in the two years preceding (You must fill out a separate Waiver Form. The waiver must be grant	nted by the Board before your license will be renewed.) See Instructions for CME				
requirements. Do not submit documentation of your CME's with yo	ur renewal application.				
OM - 9/90 - P813971	[For Office Use Only: Waiver Granted Date:/]				

FIL	LIN NAME AND NUMBER: Physician Last Name: 29NICK Registration No.: 32195
10.	My medical malpractice insurance is covered by (a) INSURANCE CARRIER X or (b) LETTER OF CREDIT
	List Insurer: MED. MALPRAC. INS ASS. : 110 WILLIAM ST. NYC 10038
	Alternatively, indicate as follows: 1 am registering with ACTIVE status, but 1 am not covered by medical malpractice insurance because 1 am (Check one): (i) NOT INVOLVED IN DIRECT/INDIRECT PATIENT CARE: (ii) OTHERWISE EXEMPT:
	(State how otherwise exampt):
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 <u>previously</u> 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):
	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 !) 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) (<u>See</u> instruction booklet.) a) How many hours per typical week are you currently involved in <i>outpatient</i> care in MA? <u>C</u> hrs./wk. in MA. b) How many hours per typical week are you currently involved in <i>inpatient</i> care in MA? <u>C</u> hrs./wk. in MA.
14.	Principal Work Setting. a) What is your principal work setting? (See Table 6) 1 5
_	
Refe	stions 15 through 22 refer to the <u>past four years</u> only. Check either YES or NO (not N/A) to <u>each</u> question. Provide details on Form 15A. In the instruction booklet for additional information.
Refe	r to the instruction booklet for additional information. Yes No.
<u>Refe</u>	r to the instruction booklet for additional information.
15. 16. 17.	r to the instruction booklet for additional information. Yes No. 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. 16. 17.	Yes No Has any pending or new medical maintenance claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any pending or new criminal proceeding other than a minor traffic offense?
15. 16. 17.	Has any pending or new medical maintenance claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
16. 16. 17.	No has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
15. 16. 17. 18.	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Are any formal disciplinary charges pending or new criminal proceeding other than a minor traffic offense? 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)?
15. 16. 17. 18. 19. 20. 21.	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a detendant in any pending or new criminal proceeding other than a minor traffic offense? 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)? 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? Have you withdrawn an application for a medical license or been denied a medical license for any reason?
16. 16. 17. 18. 19. 20. 21. 22.	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Have you been a defendant in any pending or new criminal proceeding other than a minor traffic offense?
15. 16. 17. 18. 19. 20. 21. 22. Pur Pur tax	No. Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)? Are any formal disciplinary charges pending or new criminal proceeding other than a minor traffic offense? Are any formal disciplinary charges pending or has any disciplinary action (as defined by Board regulationsSee Instructions) been taken against you by any governmental authority, hospital or other health care facility, or professional medical association (international, national, state or local)?
16. 16. 17. 18. 19. 20. 21. 22. Pur pur tax	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. 16. 17. 18. 19. 20. 21. 22. Pur pur tax oou	Has any pending or new medical maipractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?
16. 17. 18. 19. 20. 21. 22. Pur tax oou I ce	Has any pending or new medical malpractice claim been made against you (whether or not a lawsuit was filed in relation to the claim)?



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 we The Board will charge a fee for each copy. Remit \$250.00 for renewal fee. Add late fee of \$25.00, if necessary.	ill need copies for credentialing and other purposes. Return renewal application in GREEN envelope. Enclose check with coupon in BLUE envelope.		
Registration No.: 32195 Renewal Date: 09/14/	97 SEP LO 1997		
1. Activity Status: Active Retiring (Check only one) Inactive *(see below) Do not w	(see instructions) vish to renew		
2. Other Name(s), if any, under which you were licensed:	Corrections (type or print)		
	Other Name(s):		
3. A)Mailing/Business Address:	3.4 May 2.4 A.4 Lay		
GERALD ZUPNICK, M.D.	Mailing Address: City/Town: State:		
GERAND ZOFRICK, M.D.	Zip: Country:		
B) Home Address:	Other Address:		
	City/Town: State:		
	Zip: Country:		
Home Phone: Business Phone: (516)883-2526	Home: (
4. A) Date of Birth: C) Sex: M B) Lic. Issue Date: 04/16/70 D) SS#:	Date of Birth (M/D/Y):/_ Sex (M/F): Lic. Issue Date (M/D/Y):/ SS#: Full Name of Medical School:		
5. A) Name of Medical School:			
University of Louisville Sch.of Med., Hlth.Sci.Ctr. B) Year Graduated: 68 C) Degree: MD	Year Graduated: Degree (MD/DO):		
6. Specialty Code(s) (See Table 1) Code(s) Hours per Week in Mass.	Code(s) Hours Per Week in Mass.		
FP 0 Family Practice GYN 0 Gynecology	If OS, Print Specialty:		
7. Current American Board of Medical Specialties Certifica Code: Code:	tion (See Table 2) Code: Code:		
8. Drug License Numbers, if any: A) Federal (DEA):	Federal (DEA):		
A) Federal (DEA): B) Massachusetts:	Mass:		
9. A) Other states where you are now licensed to practice	Abbr.		

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

Abbr:

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

PRINT NAME AND NUMBER: Last Name: ZOPNICK	Registration Number:	32195
10. A. Current health care facilities at which you have completed the credentialing process for the Table 3 and place a check mark next to those health care facilities where you have admittin Facility Code: / (AP) Facility Code; / (AP)	g privileges (AP),	
Facility Code: / (AP) Facility Code: / (AP) Facility Code: / (AP) Facility Code: / (AP) If 999, print name(s):	Facility Code:	_/_(AP) _/_(AP)
B. Additional health care facilities at which you previously held privileges or with which yo (See Table 3)	ou were associated in the past t	wo (2) years.
Facility Code: Facility Code: Facility Code: Facility Code If 999, write Name(s):	E Facility Code:	
If 999, write Name(s):	of Credit	
Alternatively, indicate as follows: Lam registering with Asti		
Alternatively, indicate as follows: I am registering with Active status but I am not covered ! I am (check one) a X Not involved in direct/indirect patient care in Massachusetts	b) Otherwise exempt	ace because
Please explain exemption:		
 12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? 13. A. What is your principal work setting? (See Table 4) 1 5 	(check one)	es 🕱 No
B. Care of patients in Massachusetts (see instruction booklet).		
Average weekly hours involved in: a) outpatient carehrs/wk b)	innations one A buston	
2) What is the approximate percentage of your patient care hours in primary care? 10	on mpanent care nrs/wk	
PART A	, , , , , , , , , , , , , , , , , , , 	
Questions 14 through 22 refer to the past two (2) years only. Check either YES or NO details on Form R for all YES answers except for question 22. Refer to the instruction definitions. IN THE PAST TWO (2) YEARS:	booklet for additional info	ion. Provide ormation and YES NO
14. CLAIMS MADE: Has any medical malpractice claim been made against you that has not yet be adjudicated, whether or not a lawsuit was filed in relation to the claim?	en finally settled or	169 140
15. CLAIMS RESOLVED: Has any medical malpractice claim that has been made against you been otherwise resolved, whether or not a lawsuit was filed in relation to the claim?	1	
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to pra- professional conduct in the practice of medicine, been filed against you or been settled, adjudicate	ctice medicine, or your	
17. Have you been charged with any criminal offense, other than a minor traffic violation?	j	İ
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or stand governmental authority, health care facility, group practice or professional society or association?	1	
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or sedenied or restricted by any state or federal agency?	i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	
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 placed any condition related to professional competency or conduct on your coverage or have you limited or terminated your insurance coverage in response to an inquiry by a professional liability in the professional liability	ge or co-payment, or	
2. Have you completed your CME requirements preceding your renewal date (see instruction booklet)	nsurance provider?	
Waiver requested (weiver form to 20 days)	ogram exemption	
See Instructions for CME requirements. Do not submit documentation of your CMEs with your		
RENEWAL APPLICATION CONTINUED ON DAGE 2. ALL OURSESSION	our renewal application.	
RENEWAL APPLICATION CONTINUED ON PAGE 3. ALL QUESTIONS ON PAGE 3.	ART B MUST BE ANSWI	ERED.
gnature	Date: 8 /1)	(47)
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BOARD OF REGISTRATION IN MEDICINE

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

SOC. SEC NUMBER, OPTIONAL	
	San Jan

	LICENS	E NUMBER	PAY THIS FEE		DATE TO BE RENEWED		LATE FEE	
CODE	TYPE	REGISTRATION NO.	AMOUNT	7 22	MO	DA	YR	- CATEFUL
MD	1.	32195	\$100	100	09	14	87	

GERALD ZUPNICK

∋50

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

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

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_ZURNICK	2. Date of Birth: 1. MONTH DAY YEAR
3. Medical School: UNIV. OF LOUICYILLE M.D.? D.O.? (Check One.) 4. Country where Medical School located: U.S.A. 5. Date of Graduation: J	WWE 1968?
6. American Specialty Board Certified? (Check if yes.) Which Boards?	
	PRIVATE OFFICE 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:	Y-GA-FL-CT
13. States other than Massachusetts in which you are presently licensed to practice: 14. List any other states where you were previously licensed to practice:	YES NO
 Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed Have you, at any time, been a detendant in any criminal proceeding other than minor traffic offenses? Are any formal disciplinary charges pending or has any disciplinary action been taken against you in the last ten y authority, by any hospital or health care facility, or by any professional medical association (international, national Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, or have you been called before or warned by this state or any other jurisdiction including a federal agency, at any including a federal agency. Have you ever withdrawn an application for medical licensure or been denied a medical license for any reason? 	rears, by any governmental
20. Have you ever had any mental illness which has impaired your ability to practice medicine or to function as a stude 21. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a stude	
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:	PRIS
HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT ALL INFORMATION ON THIS FORM (FRONT AND BAC PURSUANT TO CHAPTER 475 OF THE ACTS OF 1985, I WILL NOT CHARGE TO OR COLLECT FROM A MEDICARE BI ABLE CHARGE FOR MY SERVICES. PURSUANT TO M.G.L. C. 62C, § 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLI RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW. PLEASE NOTE: THIS APPLIES EVEN IF YOU RESI	ENEFICIARY MORE THAN THE MEDICARE REASON-
DATE:	SIGNATURE 5 Quy 87



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

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					(FIRST:)	PEKHL	7	,(M.1.:)
b) Other Name(s),	if any, that w	NII WATA AVAT	linensed under	·				
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d) Telephone (Busi	ineas): 🛐 1	<u>અલુકુ</u> મુ	25.6	Extension	2. e) Telephor	e (Home) <i>(O</i> p	tional): t	
Date of Birth (MO/				x: MALE_X FEMALI				
a) Medical School	Code (See 76	edie 1): K	007 #99	999, write Name:				
o) Year Graduated:	1968	6. 0)	Degree: M.D. 2	<u>K</u> D.O				
d) Country: U.S)	Canada_	Code if 0	Other (See Table	2):#999), write Name:			
Work Setting (Circl	e and Indica	te Percent(%)) of Practice Tim	e):				
10 Hospital	_	%		te Office	100 %		rtnership/Group P	ractice %
25 Clinic		%		tai Health Center	% ev		irsing Home	 %
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30 Administrati 50 Medical Res	search	·%	99 Oti	her		% %		
				Time: <u>55</u> % S	ipecialty Code: (Y N Perce	nt of Practice Time	: <u>45</u> %
a) Are you Americ	an Specialty	Board Certif	fied? (Y/N) <u>N</u>	10. b) If YES, circle	which Board(s)	:		
Al Board	of Allergy & I	mmunology	NM	Board of Nuclear	Medicine	P\$	Board of Plastic	Surgery
	of Anesthesis			Board of Obstately	cs & Gynecology	, PM	Board of Prever	itive Medicina
			OG					
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Massachusetts Board of Registration in Medicine 1989-1991 Renewal Application, Page 2 of 2

Fill In name and number.	Physician Last Name:	ZUPNI	CK				Registrati	ion No.: <u>3. 2. 1</u>	٩ خ
	ou are now licensed to prac	tice (Abbreviate):	ĽИ	<u>CA</u>	EL	K 7	GA	DC	
2. b) States where you pre	eviously were licensed to pra	ctice (Abbrevlate): M7	<u> </u>	ET	R.J	<u>GA</u>	DC	
3. I am applying to be reg	istered with the following sta	atus: A	CTIVE	*IN/	ICTIVE	H ACTIVE, E	inswer questio	ns 14. a) through o	c).
Category is 45 hre	C.M.E. requirements in the s., Category II: <u>40</u> hrs., (R You must fill out a separa	sk-Management	: <u> 10 </u>	ewai date as i.); Reside	follows: <i>(Fill I</i> ncy Program i	n # of hours o			i ver.) ;
insurar	tice insurance is covered by as follows: I am registering	Instituti	l aniussi no	etter of Cred	At;	, -		identify the name	
NOT INVOLVED IN D	RECT/INDIRECT PATIENT	CARE	OTHERWIS	EXEMPTE) X (State ho)	WNO DIREC	T OK IND	HALECT KEYOU	MAN TO
•	ime in Massachusetts: 👲							issachuse t	T5
uestions 15 through 17 re	fer to the <u>past four years</u> only	y. Check either Yi	ES or NO (no	ot N/A) to <u>ea</u>	<u>on</u> question. F	Provide details	an Form 15A,	attached. <u>Yes No</u>	2
5. Has any pending or nev	w medical malpractice claim	been made agai	inst you (wh	ether or not	a lawsuit was t	filed in relation	to the claim)1	}	
	dant in any pending or new								
 Are any formal disciplin against you by any gov national, state or local) 	nary charges pending or has rernmental authority, hospite ?	any disciplinary a al or other health	action (as d care facility	efined by Bo , or profession	ard regulation nal medical a	s-See Instruc ssociation (int	tions) been tak ernational,	en	
	If you answered 'Y	-		•				********	**
	fer to the past four years only								
	pasess, dispense or prescrib- before or been warned by thi	a anatrollad subs	tances basi	habbanaue e	revoked den	led restricted	surrendered.	Of .	-
	application for a medical lic								
	tal lliness which has impaire								
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	ou been in the past, depend								
. Have you, for any reaso	en, lost American Specialty E	Board Certification	n?				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	************	
i. Have you been denled	recertification by one of mor	re specialty board	de? #YES, !	ist Board(s):				1414141414141	
Circumstances of restri	lction:								
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Withdrawai or Denial of State:	License Attach additional s Year:					denied (revol	ked, not renew	ed, or otherwise	
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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, blease read the instruction book	5 2003 Let. Copy this form and all attachments for your own records; you will
need copies for credentialing and other purposes. This green envelope at least 4 weeks before your renewal da	s completed renewal forms with with the life of the li
•Remit \$400.00 for renewal fee (non-refundable) •Add late fee of \$25.00, if necessary.	
	tion for accuracy and completeness. Make any corrections or
1. Current Status: Active Registration 1	•
If you want to change your current status, please check one	g of the following boxes to indicate your <u>new</u> status: (Check only one)
Active Retiring (see instructions)	☐ Inactive (see instructions) ☐ Do not wish to renew
2. Other Name(s), if any, under which you were licensed:	Please make corrections (print)
A) Mailing/Business Address: 3. GERALD ZUPNICK	Other Name(s) Name Change (enter name below)
B) Home Address: OLD ADDRESS -> USER USER	City/Town: State: Zip: Country:
Home Phone: Business Phone:	Business Telephone: () Home Address: USE (A) WAIL WG 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 7. (Current American Board of Medical Specialties Certification (See Table 2)
c) SS#: 5. a) Name of Medical School: University of Louisville Sch. of Med., Hlth. Sci. Ctr. a	Code: Code: Crug License Numbers, if any: Drug License Numbers, if
GYN 0 Gynecology	
10. List all current health care facilities at which you are affilial care. (Supply the codes from <u>Table 3</u> and place a check mark Next to each facility, write the approximate percentage of patients.)	nted or have completed the credentialing process for the provision of patient next to those health care facilities where you have admitting privileges (AP). In the care hours that you provide in each facility) No affiliations/(AP) % Facility Code:/(AP)%
Facility Code: / (AP) % Facility Code: If 999, print name(s):	/(AP)% Facility Code:/(AP)%/(AP)% Facility Code:/(AP)%

PRINT YOUR LAST NAME:	ZUPNICK	LICENSE NUMBER	1: <u>32195</u>
11. My medical malpractice insurance		Carrier	
Insurer's name. (Required): 1	MIP	Policy dates: From: 🥞 / 1 /	03To: 9/1/04
Alternatively, indicate as follows because I am: Check One:	I am registering with Active	status but I am not covered by medical patient care in Massachusetts A	I malpractice insurance
Otherwise exempt Please exp	ain exemption:		
 What is your principal work setti for the provision of patient care y 	ig? (See <u>Table 4</u>) <u>2 5</u> ou must complete <u>question #10</u>	If you are affiliated with a healthca on page 1 and list your affiliations.	re facility or credentialed
13. Care of patients in Massachusetts	·r	-	9 - 7 -
_ •	· -	hrs/wk B) outpatient care	// hrs/wk
7		nours in primary care?%	romm v rommo a rom
		ST TWO (2) YEARS (SEE IN	
question. Provide details on Form !	for all YES answers (except	r last renewal application. Check eit question 22). Refer to instructions Do not answer NA or the form will	for additional information
1001 1000 100			
14 CY AIMS MADE (Now on Bond	thall the same madical and	ctice claim been made against you mat	YES NO
yet been finally settled or adjustic	nea, whether or not a lawsuit v	vas filed in relation to the claim?	
15. CLAIMS (Resolved): Has any	medical malpractice claim that	has been made against you been settle	ed,
adjudicated, or otherwise resolved 16. Has any lawsuit, other than a med or your professional conduct in the otherwise resolved?	ical malpractice suit, which is a	filed in relation to the claim? related to your competency to practice ed against you or been settled, adjudic	medicine, ated or
17. Have you been charged with any	riminal offense?		
 Have you been charged with or di any governmental authority, healt 	sciplined for any violation of la care facility, group practice o	iws, rules, by-laws or standards of pract r professional society or association?	ctice of
 Has your privilege to possess, dispressricted by, or surrendered to an 	ense or prescribe controlled su state or federal agency?	bstances been suspended, revoked, de	nied,
20. Have you withdrawn an application	1	•	l I
 Has any professional liability insu co-payment, or placed any conditi you voluntarily restricted, limited professional liability insurance pre 	on related to professional comp or terminated your insurance or	ed, terminated, imposed a surcharge or betency or conduct on your coverage, of overage in response to an inquiry by a	or have
22. CME CERTIFICATION: Have	you completed your CME requ	irements preceding your renewal date	? 🛛 Yes 🗌 No
CME Waiver. CME waiver f	orm must be submitted at least	30 days prior to license expiration date	e,
CME EXEMPTION: Check on		-consequently our warm town to the first	•
		nit documentation of your CMEs wi	
and the punishment for failure	to comply.	to report abuse or neglect of children	· ·
amount.		from a Medicare beneficiary more tha	
Massachusetts state tax return G.L. c. 62E; and withholding	s and payment of all Massachus and remitting child support pure	with all laws of the Commonwealth relatests state taxes; reporting of employee suant to G.L. c. 119A. (See instruction	es and contractors under us).
I hereby certify under the penalties	of perjury that all information	on on this Renewal Application, Par	t B and Form R is true.
Signature:			Date: 8 / 29 / 03
YOU MUST SIGN AN	D INCLUDE PART B.	WITH YOUR RENEWAL AP	PLICATION
<u>Board Régulations re</u>	quire that you notify the	Board, in writing, of any chang	<u>e of address</u>

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

• Copy this form and all attachments for your own records, you wi	read the instruction booklet.		
• Remit \$250.00 for renewal fee. • Add late fee of \$25.00, if necessary	• Enclose check with coupon in BLUE envelope		
Registration No 32195 Renewal Date 09/14/19	of Medicine Current Status Adire & CENTRE		
If you want to change your current status, please indicate below (
man A	tive (see below *) The net wish to real 1999		
2 Other Name(s), if any, under which you were licensed	Please make corrections (type or print) deard of Hegistration in Medicine		
	Other Name(s)		
A) Mailing/Business Address: GERALD ZUPNICK	Mailing Address City/Town State		
HAD	Zip Country		
B) Home Address	Other Address City/Town State Zip Country		
Home Phone	Home ()		
Business Phone	Business (
4 A) Date of Birth Sex M B) SS#	Date of Birth (M/D/Y)/_/ Sex M F		
5 A) Name of Medical School University of Louisville Sch of Med, Hlth.Sci Ctr	Full Name of Medical School		
B) Year Graduated 1968 C) Degree M D	Year Graduated Degree M D D O		
6 Specialty Code(s) (See Table 1) <u>Code(s)</u> Hours per Week m Mass	Code(s) Hours Per Week in Massachusetts		
GYN 0 Gynecology	If OS, Print Specialty		
7 Current American Board of Medical Specialities Certification (See Code Code	Table 2) 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	Abbr		
B) States where you previously were licensed to practice Abbr NY CA DC GA FL KY	Abbr		

^{*}If requesting <u>Inactive</u> status, you agree not to practice medicine, including writing prescriptions, in Massachusetts.

PR	INT NAME AND NUMBER Last Name Registration Number
10 the	Current health care facilities at which you have completed the credentialing process for the provision of patient care. Supply codes from Table 3 and place a check mark next to those health care facilities where you have admitting privileges (AP). Next to the facility, write the approximate percentage of patient care hours that you provide in each facility.
T _a	citity Code / (AP) % Facility Code / (AP) % Facility Code / (AP) %
Fa	c.'ny Code (AP) % Facility Code / (AP) % Facility Coce /(AP) %
	999, pr nt name(s)
1.	My medical maipractice insurance is covered by a) Trisurance Carrier b) Letter of Cred :
11	Name of Insurer in EDI Ac they that The instrument in the A terrative y, include as follows
	n registering with Active status but 'am not covered by medical inalpractice insurance because I am (check one)
	Not involved in direct/ind rect patient care in Massachuset s b) (Offerwise exemp)
Þ·e	ese explain exemption
	Are you currently in a post-graduate training program in Massachusetts as a resident or clinical fellow? (check one) Tyes Though
13	A What is your principal work setting? (See Table 4) / 5
	B Care of patients in Massachusetts (see instruct on booklet)
	1) Average weekly nours involved in a) outpatient care ins/wk b) impatient care ins/wk
	2) What is the approximate percentage of your patient care nours in or many care?%
PA	RT A - QUESTIONS REFER ONLY TO THE PAST TWO (2) YEARS
	estions 14 through 22 refer to the past two (2) years only Check ears YES or NO (NOT N/A) to exchaussion Provide
date	arks on Rorm R for all VES answers except for question 22. Refer to the instruction booklet for accinonal information and
defi	nitions. You must answer ALL questions, or this form will be returned to you and your license renewal may be delayed
	YES KO
и	CLAIMS MADE Has any medical malpractice claim been made against you that has not yet been finally
	sett ed or adjudicated, whether or not a lawsuit was filed in relation to the claim?
	CLAIMS RESOLVED Has any medical maintractice claim that has been made against you been settled adjudicated, or otherwise resolved, whether or not a lawsuit was field in relation to the old m?
	Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medical malpractice of medicine, been filed against you or been settled adjudroated of otherwise resolved?
17	mave you been charged with any criminal offense, other than a minor traffic violation?
.8	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	Pas your privilege to possess, dispense or prescribe control edispostances been surrencered to or suspenced revoked denied or restricted by any state or federal agoncy?
20	Have you withdrawn an application for a medical license or been denied a medical license for any reason?
20	Has any professional liab, ity insurance provider restricted. I mited, terminated imposed a surcharge or
	co-payment or piaced any condition related to professional competency of conduction your deverage or have you voluntarily restricted a mitted or term nated your insurance coverage in response of an inquiry by a professional liability insurance provider?
22	CME CERTIFICATION Have you completed your CME requirements preceding your renews, date? Yes No
	CME Walver reduested (CME waiver form due 30 days prior to cale of license exhibition)
See	Instructions for CME requirements. Do not submit cocumentation of your CMEs with your renewal application
c	Pursuant to GL c 112, § 2, I will not charge to on collect from a Medicare conefficiery more than the Wed care fee schedule a mount
0	Pursuant to G L c 62C, § 49A, to the best of my knowledge and be eff. I rave T en Viassachusetts state fax refurms and ball at Massachusetts state taxes that are required under law NOTE. This applies even flyoures de out-of-state or out of the United States.
o	Pursuant to G L c 112, § 1A, I will fuffill my obligation to report abuse or neglect of the eren as required by G L c 119 § 514
0	I hereby certify under the penalties of perjury that all the information on the Renewal Application and Form K. 5 the
-	Energy corrupt without market and to by freezers in an interest of the
S.g	nature Date//





Before proceeding, please read the instruction booklet.

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

 Copy this form and all attachments for your own records; you will 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
Registration No 32195 Renewal Date 09/14/5	97. SF210 1997
(Check only one)	(see instructions) ish to renew
2 Other Name(s), if any, under which you were licensed	Corrections (type or print)
3 A)Mailing/Business Address.	Other Name(s)
, -	Mailing Address
GERALD ZUPNICK, M.D.	City/Town State
	Zip Country
B) Home Address:	Other Address
	City/Town State
······	ZipCountry
Home Phone () - Business Phone (516) 883-2526	Home () Business ()
A) Date of Birth C) Sex M B) Lic Issue Date 04/16/70 D) SS#	Date of Birth (M/D/Y) / / Sex (M/F) Lic Issue Date (M/D/Y) / / SS#
5 A) Name of Medical School	Full Name of Medical School
University of Louisville Sch.of Med., Hlth.Sci.Ctr.	
B) Year Graduated 68 C) Degree MD	Year Graduated Degree (MD/DO)
Specialty Code(s) (See Table 1) <u>Code(s)</u> <u>Hours per Week in Mass</u>	Code(s) Hours Per Week in Mass
FP 0 Family Practice	
GYN 0 Gynecology	If OS, Print Specialty
Current American Board of Medical Specialties Certification	on (See Table 2)
Code Code	CodeCode
Drug License Numbers, if any	F.J. L/DFA
A) Federal (DEA) R) Massachusetts	Federal (DEA) Mass
B) Massachusetts	Mass
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
Abbr NY CA DC GA FL	Abbr :>>

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

UNT NAME AND NUMBER: Last Name ZOPNICK Registration Number	
A Current health care facilities at which you have completed the credentialing process for the provision of patient care. Suppl 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) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP) Facility Code / (AP)	_/_(AP) _/_(AP)
B Additional health care facilities at which you previously held privileges or with which you were associated in the past tw (See Table 3)	
Facility Code Facility Code Facility Code Facility Code Facility Code Facility Code	
My medical malpractice insurance is covered by a) Insurance Carrier b) Letter of Cred t	
Name of Insurer TILMIC	nce necalist
Alternatively, indicate as follows: I am registering with Active status but I am not covered by medical malpractice insurant I am (check one): a) Not involved in direct/indirect patient care in Massachusetts: b) Otherwise exempt Please explain exemption	
Are you currently in a post-graduate training program in Mass as a resident or clinical fellow? (check one)	res ⊠No
A What is your principal work setting? (See Table 4) 1 5	
14	
1) Average weekly hours involved in a) outpatient care hrs/wk b) inpatient care hrs/wk	٨
2) What is the approximate percentage of your patient care hours in primary care? 10%	
ART A	~ ·
equestions 14 through 22 refer to the past two (2) years only Check either YES or NO (NOT N/A) to each que etails on Form R for all YES answers except for question 22. Refer to the instruction booklet for additional in	stion. Provid nformation an
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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 Fe 32195 ACTIVE \$250.00 39/14/93 \$25.00	Correction of Maling Address:
Mailing Address:	Address (Mailing)
SERALD ZUPNICK, M.D.	Cota Trans
	City/TownState:
	Country Code (See Table 1):
Directions: Staple check to bottom of form. Add late fee if necessary	For Office Use Only
 Questions 1-8 include information from Board files. Please correct as re 	ECCSSHIV III HIC DUXES
provided on the right hand side of the page	M.R. SEP 1 5 1993
 Before proceeding, please read the instruction booklet. Some questions Make a copy of this form and all attachments for your own records 	
for credentialing and other purposes. The Board will charge a fee for e	
• Enclose the \$250 00 renewal fee by means of a certified check, money of	
payable to the Commonwealth of 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 (Home):
	City/Town. State. Zrp
	Country Code If 999 print Country
b) Address (Business)	Address (Busmess)
of Marios (Deputes)	Cuty/Town Country Code If 999 print Country
	Country Code If 999 print Country
3. Date of Birth: Sex. A)	Date of Birth (M/D/Y) Sex (M/F)
Lie Issue Date: 34/10/73 SS#:	Lic Issue Date (M/D/Y)/ SS#
Telephone Number:	Home. () Business ()
Home Business (51o) 8≥3-2526	
	Full Name of Medical School
4 Name of Medical School: university of Louisville School	
med.znlth.Sci.Ctr.	Year Graduated Degree (MD/DO)
Year Graduated. c8 Degree: MD	Teat Gladuated Degree (WD)DO)
-	
5. a) Other states where you are now licensed to practice (Abbr):	CA DC GA FL
b) States where you previously were licensed to practice (Abbr): 14 Y	CA DC GA FL
	Code Hours per Week in Mass
6 Specialty Code(s) (See Table 2)	
Code Hours per Week in Mass	
FP 0 Family Practice	If OS, print specialty
SY': O Gynecology	
7 a) If you are currently American Specialty Board Certified, enter Codes	(See Table 3)
Code. Code	CodeCode
b) If you previously were American Specialty Board certified, but are n	o longer,
please enter codes of prior certification: (See Table 3)	
Code Code	Code Code
8. Drug License Number(s), if any. a) Federal (DEA)	Federal (DEA).
b) State (MA)	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 Num	ber: 32112
10. Activity Status: I am applying to be regu				
 I hereby certify that if requesting Inac 	ive status, I will not practic	e medicine, Including write	ing prescriptions, in	Massachusetts.
11. My medical malpractice insurance is cover List Insurer: MED. MAL?	red by (a) INSURANCE C.	ARRIER of (b) LETTI \o WILLIAM ST ;	NYC 10038	If applicable, check one
Alternatively, indicate as follows: I am regist	ering with ACTIVE status, b	ut I am not covered by medi	cal malpractice insur	ence because I am
(Check One) (1) NOT INVOLVED IN DIRE (State how otherwise exempt):				MPT-
12. Current Health Care Facility Affiliations admitting privileges (AP). Facility Code: / (AP)			ext to those facilities ty Code:	
Facility Code: / (AP)		/ (AP) Facili	ity Code:	/ (AP)
If 999, print name(s):			· · · · · · · · · · · · · · · · · · ·	
Additional hospitals at which you previously (See Table 4.)				•
Facility Code: Facility Code			de Fa;	allity Code:
If 999, write name(s):				
13. Are you currently in a post-graduate train	, , , , , , , , , , , , , , , , , , , ,	dent or elimical fellow?	esNo	(Check one)
14 a) What is your principal work setting?		•		
 b) Care of patients in Massachusetts (M 1) How many hours per typical weel 11) How many hours per typical weel 	k are you currently involved	m outpatient care in MA?	O hrs/wk m MA O hrs/wk m MA	•
Questions 15 through 23 refer to the pass Provide details on Form 15A for all YES				-
IN THE PAST TWO YEARS:				YES NO
IN THE PAST TWO YEARS: 15. Has any medical malpractice claim been n	nade agamst you, whether or	not a lawsuit was filed m re	lation to the claim?	••
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15. Has any medical malpractice claim been n	offense, other than a minor this inscription of	raffic violation? of the rules, by-laws or stand	ards of practice of an	 y
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Commonwealth of Massachusetts Board of Registration in Medicine Ten West Street, 3rd Floor, Boston-Massachusetts 02111 1989-1991 Physician Registration Rengrat Application, Page 1 of 2

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

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GERALD ZUPNICK

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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 Χ.

CHANGES BELOW

DO NOT WRITE BELOW THIS LINE

TIONS YOU MUST CHECK THIS BOX

THE ENCLOSED INSTRUCTIONS FOR DETAILS)

APP, CANT S SIGNATURE PAY THIS AMOUNT LICENSE NUMBER DATE TO BE RENEWED LATE FEE мо DA REGISTRATION NO CODE 15 86 100.00 100.00 01 MD 32195

PLEASE PRINT ANY NAME OR ADDRESS

GERALD ZUPNICK

PLEASE USE THE ENCLOSED RETURN ENVELOPS

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS

ON THE REVERSE SIDE OF THIS APPLICATION SEF

IF YOU ANSWERED "YES TO ANY OF THESE QUES-

NOTE!

THIS APPLICATION MUST BE SIGNED AND RETURNED WITH A \$100 PAYMENT A CERTIFIED CHECK OR MONEY ORDER FOREFERRED PERSONAL CHECKS AS ACCEPTABLE PAYABLE TO

COMMONWEALTH OF MASSACHUSET PO BOX 6

BOSTON MASSACHUSETTS 02297

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POOR ORIGINAL COPY

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rint Name GERALD ZUPNICT ()	Date of Birth			
dedical School UNIA OF LOUSAIL E Date of Graduation ou must read the instructions enclosed with this form to answer questions 1-12	6/68			
1 Principal Speciaity(.es) TY-GYN	2 Principal work setting	RUATE C	FF CE	
3 Home address STME HS FRONT	Principal ousiness address	SAME A	S FRONT	
5 List all hospitals at which you have currently effective privileges				
6 States other than Massachusetts in which you are licensed to practice 1/1	<u> </u>		1	A
7 Have you been a defendant in any malpractice suit commenced since 10/1/83?			YES	NO
8 Have you been a defendant in any criminal proceeding other than minor traffic offenses comm	nenced since 10/1/83?			
9 Has any disciplinary action been taken against you in the last ten years, by any governmental professional medical association (international national state or local)?	authority, by any hospital or he	ealth care facility o	oy any	
10 Has your privilege to possess dispense or prescribe controlled substances ever been suspend	led or revoked in this state or a	ny other?		•
11 I have completed my C.M.E. requirements between 1/15/84 & 1/15/86 as follows PHYCLA	ns regaward o	FAMA 19	.83	
12 I am an active inactive practitioner (Check one)	1/ 1		- (
HEREBY CERTIFY UNDER THE PENALTY OF PERJURY THAT THE ABOVE INFORMATION OF THIS CARD)	TION IS TRUE		SIGNATURE	
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Massachusetts Physician Renewal Application Physician Name: GERALD ZUPNICK License No.: 321

License No.: 32195

PARIA 1) Current Status: Active I	Renewal Due Date: 0	8/17/2005	Birth Date:
If you want to change your current sta		of the following boxes to	indicate your <u>new</u> status:
(Check only one). (See Renewal Inst	tructions, page 3.) Inactiv	е Пв	o not wish to renew
Li Active Li Retning	i i i i i i i i i i i i i i i i i i i		o not wish to lone w
2) Addresses & Contact Information. Please required to notify the Board of Registration Business addresses <u>CANNOT</u> be a Post Office 2a) MAILING ADDRESS	in Medicine within ice Box.		f address. Home and
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2b) HOME ADDRESS		Home Address:	
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2e) BUSINESS ADDRESS 29-28 41st Avenue Long Island City, NY 11101		City/Town: NEW	BLEECKER STREET YORK State: NY untry: USA
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3) E-mail Address:			
4) Fax Number:			
5) Specialties (See Renewal Instructions, pag	ge 4.) Delete?	Additional specialt	ies:
Family Practice			
Gynecology	О		
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6) Current American Board of Medical Sp (See enclosed instructions and Renewal Instru	ecialties (ABMS) or . uctions, page 4.)	American Osteopathic	Association (AOA) Information
List Certifying Board(s) below:		rtificates and Subspeci dditional Certification	
Board Name ABMS or AOA	Certificate/Subspe	ialty	Correct? Delete?
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Physician Name: GERALD ZUPNICK License No.: 32195 (See Renewal Instructions, page 4.) Please make corrections as necessary 8a) Other states where you are now licensed to practice (Abbr.) 7) Drug License Numbers, if any: DC GA a) Massachusetts: 8b) States where you were previously licensed (Abbr.) b) Federal (DEA): CA GA NY DC c) Federal (DEA) XS: 9) What is your principal work setting? (See Renewal Instructions, page 4.) Principal Work Setting: Clinic Please enter the <u>approximate</u> number of work hours at your principal work setting: 2410) 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. Please enter the approximate number of work hours for each Health Care Facility below: No Affiliations Staff Category Approximate Health Care Facility (See Renewal Instructions, page 4.) Delete? # Hours per Week Current Change П m П П 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Change to: ____ 0 hrs/wk Average weekly hours involved in: a) inpatient care hrs/wk 0 hrs/wk Change to: hrs/wk b) outpatient care _ 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: From ___/_ / Policy dates: (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):

Page 2 of 5

08/30/05/80

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License No.: 32195 Physician Name: GERALD ZUPNICK

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

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: Yes □ No a) Have you completed your CME requirements preceding your renewal date? 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.) ☐ Residency/Fellowship training

☐ Inactive Status

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CME EXEMPTION: (check one)

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Massachusetts Physician Renewal Application

Physician Name: GERALD ZUPNICK License No.: 32195

PHYSICIAN PROFILE	PHY	SICI	ΑN	PRO	FHE
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I have reviewed my Physician Profile at <u>profiles.massmedboard.org</u> and confirm that the information is accurate.

I have reviewed my Physician Profile and attached a copy of the Profile <u>with corrections</u>.

My status is lnactive 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.

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

Physician Name: Gerald Zupnick, M.D. License No.: 32195 PART A Renewal Due Date: 08/17/2007 Birth Date: 1) Current Status: Active 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.) ☐ 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 <u>CANNOT</u> be a Post Office Box. Please make corrections (print) 2a) MAILING ADDRESS Mailing Address: City/Town: State: Zip: _____ Country: ____ Check here to change this address RECEIVED **2b) HOME ADDRESS** Home Address: AUG 17 2007 State: Cîty/Town: Zip: Country: Board of Registration Home Telephone: (____)____ in Medicine Phone: Home address cannot be a Post Office Box Check here to change this address 2c) BUSINESS ADDRESS Business Address: 26 Bleecker Street City/Town: State: New York, NY 10012 Zip: Country: Business Telephone: (____)____ Phone: Business address cannot be a Post Office Box Check here to change this address Correct your E-mail and Fax Number below: 3) E-mail Address: 4) Fax Number: List Additional Specialties: 5) Specialties (See Renewal Instructions, page 4.) Delete? 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.) Undate General Certificates and Subspecialty Certificates List Certifying Board(s) below: below. Please add additional Certifications as required.

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License No.: 32195 Physician Name: Gerald Zupnick, M.D. Please make corrections as necessary (See Renewal Instructions, page 4.) 8) Other states where you are now licensed to practice 7) Drug License Numbers Corrections: NY CA DC GA FL a) Massachusetts: 9) States where you were previously licensed b) Federal (DEA): . DC GA NY c) Federal (DEA) XS: 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. Location List the names of all work sites in Massachusetts State Delete? (City or Town) (See above and description on page 4.) 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) Change to: ____ hrs/wk 0 hrs/wk Average weekly hours involved in: a) inpatient care 0 hrs/wk Change to: hrs/wk b) outpatient care 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: > I HAVE NO IDEA WHAT CRICO IS! ☐ Insurance Carrier (complete below) Current Insurance Carrier: CRICO From __/_/__ To __/__/_ Policy dates: ☐ Occurrence Policy ☐ Claims made with tail coverage Type of 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: Not involved with direct or indirect patient care in Massachusetts Check one: 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.) No Yes

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

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.

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?	
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)	
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Massachusetts Physician Renewal Application Physician Name: Gerald Zupnick, M.D. License No.: 32195			4.
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Che	eck One: PHYSICIAN PROF	<u>ile</u>	66
Ø	I have reviewed my Physician Profile at http://profiles.massme (Please note that if you changed or corrected your business ad certification and/or hospital affiliations on your renewal applied	dress, business phone number, practice specialty, board	
	I have reviewed my Physician Profile and attached a copy of t	he Profile with corrections.	<u></u>
	My status is Inactive and I do not have a Physician Profile. (Se	<u>ee</u> Renewal Instructions, page 11.)	
	<u>CERTIFICATIO</u>	<u>ns</u>	
1) i unde	certify that I have complied with my obligations to report abuse erstand the punishment for failure to comply.	or neglect of children pursuant to G.L. c. 119, sec. 51A, and	[

- 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: 8/9/0

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 R	
Physician Name: Gerald Zupnick, M.D.	License No.: 32195
NATIONAL PROVIDER IDE The primary purpose of the NPI is to uniquely identify health care provide and health care purchasers for purposes of conducting these business trait Under the final HIPAA NPI Rule, all individual and organization covere	NTIFIER (NPI) lers as "health care providers" in HIPAA standard transactions. s, such as those assigned by health plans, government programs's sactions.
In order for your license to be renewed you must take one of the foll	owing actions:
Option 1: Supply the Board of Registration in Medicine with your valid site at www.NPPES.cms.hhs.gov . Option 2: Certify you have personally applied for your NPI and you have you must notify the Board. Please complete the NPI form at the Option 3: Certify another authorized institution has applied for an NPI of institution's name). Once you have received your NPI Number Board's website (see Option 2). Option 4: Authorize the Board of Registration in Medicine to apply for a Option 5: If your license status is INACTIVE, you may elect not to obta	NPI. You can apply for an NPI directly by using the NPPES web e not received it yet. Once you have received your NPI Number, e Board's web site at www.massmedboard.org . In your behalf and you have not received it yet (supply you must notify the Board by completing the NPI form at the NPI on your behalf.
Check the appropriate box below, supply appropriate information, and si	en 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 here	by authorize the Board to apply for an NPI on my behalf.
As an <i>inactive</i> physician, I do not wish to obtain an NPI.	
Please provide the HIPAA taxonomy (specialty) codes (refer to Renewal providing the taxonomy code, please indicate your specialty in the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required if you authorize BORIM to apply for an NPI of the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code is required in the space taxonomy code	Instructions, page 21 for more information). In addition to provided (Taxonomy Description). The primary provider on your behalf.
Taxonomy (Specialty) Coo	E Taxonomy Description (Print)
Primary Provider Taxonomy:	
Provider Taxonomy:	
Provider Taxonomy:	
NPI REQUIRED INFORMAT	<u>ION</u>
In an ongoing effort to improve the quality of the information we collect, as necessary. Please note: This information is required if you authorize E	
Social Security Number:	
State of Birth (if US): Country of E	irth (if outside the US):
Gender: Male Female	
Penalties for Falsifving Information on the N 18 U.S.C. 1001 authorizes criminal penalties against an individual who in the United States knowingly and willfully falsifies, conceals or covers up fictitious or fraudulent statements or representations, or makes any false v fictitious or fraudulent statement or entry. Individual offenders are subject Offenders that are organizations are subject to fines of up to \$500,000. 18 derived by the offender if it is greater than the amount specifically authority	any matter within the jurisdiction of any department or agency of by any trick, scheme or device a material fact, or makes any false, riting or document knowing the same to contain any false, to fines of up to \$250,000 and imprisonment for up to five years. U.S.C. 3571(d) also authorizes fines of up to twice the gross gain zed by the sentencing statute.
Authorization for NPI Dis	
Check one box: I authorize I do not authorize the Board of authorized hospital, health plan, or health organization.	Registration in Medicine to provide my NP1 number to any
Please sign and date to confirm that all of the information on this for	n is true and accurate.
Signature:	Date: \$ / \(\frac{\q}{2} \) \(\text{O} \)
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'Physician Name: Gerald Zupnick, M.D. License No.: 32195 PART A 1) Current Status: Active Renewal Due Date: 08/17/2007 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.) ☐ 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 <u>CANNOT</u> be a Post Office Rox. Please make corrections (print) 2a) MAILING ADDRESS Mailing Address: AUG 29 2007 City/Town: _____ State: _____ Board of Registration Zip: _____ Country: ____ in Medicine ☐ Check here to change this address 2b) HOME ADDRESS Home Address: AUG 17 2007 City/Town: State: Roard of Registration Zip: Country: Home Telephone: (____)___ in Madicine Phone: Home address cannot be a Post Office Box ☐ Check here to change this address 2c) BUSINESS ADDRESS Business Address. 26 Bleecker Street City/Tov.... State New York, NY 10012 Zip: Country: Business Telephone: (____)__ Phone: Check here to change this address Business address cannot be a Post Office Box Correct your E-mail and Fax Number below: 3) E-mail Address: 4) Fax Number: 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 Certificate/Subspecialty ABMS or AOA Delete?

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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 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 Location State Delete? (See above and description on page 4.) (City or Town) 11) Care of patients in Massachusetts (See Renewal Instructions, page 4.) 0 hrs/wk Average weekly hours involved in: a) inpatient care Change to: _____ hrs/wk 0 hrs/wk b) outpatient care __ 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; > I HAVE NO IDEA WHAT CRICO IS! ☐ Insurance Carrier (complete below) Current Insurance Carrier: CRICO Policy dates: From _/_/ To __/ / ☐ Occurrence Policy Type of Policy: Claims made with tail coverage (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: 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.) If Yes, please complete Form PCA-O "Office Based Surgery" Form on page 8.

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

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?	770
22) CME CERTIFICATION:	
a) Have you completed your CME requirements preceding your renewal date? Yes Do	
b) If no, are you requesting a CME waiver?	
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)	

Physician Name: Gerald Zupnick, M.D.

License No.: 32195

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PAKI	<u> </u>				
Che	ck One:	PHYS	ICIAN PROFILE		
Ø	(Please note that	if you changed or corrected yo	our business address, bu	org and confirm that the information is accurate. usiness phone number, practice specialty, board our Physician Profile will also be updated.)	1.640 1.44 1.44 1.45 1.45 1.45 1.45 1.45 1.45
	I have reviewed i	my Physician Profile and attac	hed a copy of the Profi	le with corrections.	-60 30
	My status is Inac	tive and I do not have a Physic	cian Profile. (<u>See</u> Renev	val Instructions, page 11.)	
		CEI	RTIFICATIONS		, TJ.
1) I c unde	ertify that I have corstand the punishm	omplied with my obligations to ent for failure to comply.	o report abuse or negle	ct of children pursuant to G.L. c. 119, sec. 51A, and	j H
2) I c I und	ertify that I have co erstand the punishr	omplied with my obligations to nent for failure to comply.	o report abuse or neglec	et of disabled persons pursuant to G.L. c. 19C, sec.	10, and
3) I c G.L.	ertify that I have co	omplied with my obligations to I understand the punishment	o report abuse, neglect of for failure to comply.	or financial exploitation of elderly persons pursuant	. to
4) I c sec. 1	ertify that I have co 2A.	omplied with my obligations to	o report the treatment of	f wounds, burns and other injuries pursuant to G.L.	c. 112,
5) I co sec. 1	ertify that I have co 2A 1/2.	omplied with my obligations to	report the treatment of	f victims of rape or sexual assault pursuant to G.L. of	: 112,
6) I co when	ertify that I have co I have a reasonable	omplied with my obligations to e basis to believe that person v	report a physician to the report a physician to the report any provisions of the report and the	ne Board of Medicine, pursuant to G.L. c. 112, sec. of G.L. c. 112, sec. 5 or any Board regulation.	5F,
7) I ce with t	ertify that I have co he Medicare fee sc	mplied with my obligations re hedule, and I understand my o	lated to charging and cobligations under G.L. c	ollecting fees from Medicare beneficiaries in accordance 112, sec. 2.	lance
8) I ce that, p perjur	oursuant to G.L. c. (mplied with my obligations to 62C, sec. 49A, my license shal	file Massachusetts tax Il not be issued or renev	returns and to pay Massachusetts taxes, and I under wed unless I make these certifications under penaltic	stand s of
9) I ce	ertify that I have co	mplied with my obligations re	lated to the reporting of	employees and contractors pursuant to G.L. 62E.	
10) I c	certify that I have c	omplied with my obligations r	elated to the withholdin	g and remitting of child support pursuant to G.L. c.	119A.
private	e office, pursuant to	O.L. c. 112 sec. 5 and the Pa	tient Care Assessment I	t with the Board when certain adverse events occur Regulations, 243 C.M.R. 3.00 et seq. I understand the I practice report certain Major Incidents to the Board	hat
12) l c legal e	ertify that I have contity to which I have	omplied with my obligations to ve referred a patient for physic	o disclose my ownership al therapy services purs	p interest in any partnership, corporation, firm or of suant to G.L. c. 112, sec. 12AA.	her
Unde instru	r penalties of po actions, forms a	erjury, I declare that I houselind statements, and to the	ave examined this i e best of my knowle	renewal application and all its accompany edge and belief, the information contained	ing a
herei	n is true, correc	t, and complete. As an a	pplicant for renewo	al of a license to practice medicine. I	•
undei	rstand that a cri	iminal record check may	be conducted for c	conviction and pending criminal case	
licens	mation from the	e Criminal History Syste	ms Board only and	that it will not necessarily disqualify me j	from
HEHS	M/C.		ŀ		
Signati	иге:			Date:	
MAKI COPY	E A COPY OF YO OF YOUR APPL	OUR APPLICATION AND A JCATION FOR YOUR RE	ALL ATTACHMENTS CORDS, FOR CRED	S BEFORE MAILING. YOU MUST RETAIN A ENTIALING AND FOR OTHER PURPOSES.	

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

NATIONAL PROVIDER IDENTIFIER (NPD

NATIONAL I ROVIDER IDENTIFIER (NII)	- \-\{.
The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transaction. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programments are providers.	
and health care purchasers for purposes of conducting these business transactions.	₇
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 NPPE site at www.NPPES.cms.hhs.gov .	S we
Option 2: Certify you have personally applied for your NPI and you have not received it yet. Once you have received your NPI Num you must notify the Board. Please complete the NPI form at the Board's web site at www.massmedboard.org .	ıber,
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 state of the supply of the state of the supply supply the supply of the supply supply the supply supply supply the supply su	he
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):)
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 <i>inactive</i> 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 correction as necessary. Please note: This information is required if you authorize BORIM to apply for an NPI on your behalf.	ns
Social Security Number:	
State of Birth (if US): Country of Birth (if outside the US):	
Gender:	
Penalties for Falsifying Information on the National Provider Identifier Application	
8 U.S.C. 1001 authorizes criminal penalties against an individual who in any matter within the jurisdiction of any department or ager the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any factitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, ictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to \$250,000 and imprisonment for up to five 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 derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.	false years
Authorization for NPI Dissemination	
Check one box: I authorize I do <u>not</u> authorize the Board of Registration in Medicine to provide my NPI number to a uthorized hospital, health plan, or health organization.	ny
Please sign and date to confirm that all of the information on this form is true and accurate.	
Signature: Date: Date:	
2000 7 of 0	

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