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APR 1 9 2011

Board of Registration in Medicine

Application #: 248135
Date of Issue: ___/___/___

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

REDACTED COPY

FULL LICENSE APPLICATION

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

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

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

Gray, Kathryn, Johnson, ____
Last Name (type or print clearly), First, Middle, Suffix (Jr., etc.)

☒ M.D. ☐ D.O. ☒ Ph.D ☐ Other degree_____ ☐ Male ☒ Female

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

Groendyke, Kathryn, Johnson (also: Johnson, Kathryn Marie)
Entire Last Name (type or print clearly), First, Middle, Suffix (Jr., etc.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: _____

Place of Birth: Madison, Wisconsin, USA
City, State/Province/Territory, Country if not USA

*Mailing Address: _____ Telephone: _____
Number and Street

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

Home Address: _____ Telephone: _____
Number and Street

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

Business Address: n/a Telephone: _____
Number and Street

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

E-mail Address: _____ Fax number: n/a

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

*** The Board will use your Mailing Address for all correspondence**

PRINT NAME: Gray, Kathryn Johnson

Pre-medical School

			From	To
Facility: University of Wisconsin- Madison	Degree: BS		08/29/1995,	5/18/1999
Street: 333 East Campus Mall #10101	City: Madison	State: WI 53715		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Medical School

			From	To
Facility: University of Michigan	Degree: MD, PhD		08/17/1999,	04/1/2007
Street: 1301 Catherine Rd	City: Ann Arbor	State: MI 48109		
Facility:	Degree:		/ /	/ /
Street:	City:	State:		

Date of medical school graduation: 05 / 11 / 2007
Month Day Year

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

Postgraduate Education:

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

			From	To
Facility: Emory University Ob/Gyn Dept	Position: PGY1-4,		07/01/07,	06/30/11
Street: 69 Jesse Hill Jr Dr SE	City: Atlanta	State: GA 30303		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		
Facility:	Position:		/ /	/ /
Street:	City:	State:		

Examination History

Please contact the appropriate examination entity and have certified transcript of your scores sent directly to this Board. If you are using FCVS, your examination scores will be sent to the Board with your credentials packet.

List each licensure examination, U.S. or international, you have taken (USMLE, NBME, NBOME, LMCC, Etc.).If additional space is necessary, please enclose a separate sheet with your application and include all the information below. If you answer "yes" to question #5 on the Full Supplement, you must also complete the required information.

Examination	Most Recent Date taken (Month/Year)	Passed (P) or Failed (F)		Number of attempts
USMLE Step I	06/2001	☒ P	☐ F	1
USMLE Step II	CK: 09/2006 CS: 11/2006	☒ P	☐ F	1 (for both)
USMLE Step III	10/2008	☒ P	☐ F	1
NBME Part I	n/a	☐ P	☐ F	
NBME Part II	n/a	☐ P	☐ F	
NBME Part III	n/a	☐ P	☐ F	
FLEX Component 1	n/a	☐ P	☐ F	
FLEX Component 2	n/a	☐ P	☐ F	
FLEX Pre-1985	n/a	☐ P	☐ F	
NBOME Part 1	n/a	☐ P	☐ F	
NBOME Part II	n/a	☐ P	☐ F	
NBOME Part III	n/a	☐ P	☐ F	
COMLEX Level 1	n/a	☐ P	☐ F	
COMLEX Level 2	n/a	☐ P	☐ F	
COMLEX Level 3	n/a	☐ P	☐ F	
COMVEX	n/a	☐ P	☐ F	
LMCC – Single	n/a	☐ P	☐ F	
LMCC – Part I	n/a	☐ P	☐ F	
LMCC – Part II	n/a	☐ P	☐ F	
State Board Exam	n/a (State of examination)	☐ P	☐ F	

PRINT NAME: Gray, Kathryn Johnson

Hospital Affiliations and Employment

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

		From	To
Facility: n/a Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		

1. List other states (abbreviations) where you are currently or have ever had a full license: n/a
2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No
3. List Board Certification(s): n/a Certification date: __/__/__
   Certification date: __/__/__
4. List your practice specialt(ies) n/a Obstetrics and Gynecology
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Plan to practice in Boston starting as early as 07/2011; will start fellowship in MFM-Genetics at Brigham+Women's 7/2012
7. Name of Facility: Brigham and Women's Hospital
   Address: 75 Francis St City: Boston MA 02215-1213
8. Anticipated starting date in Massachusetts: 07/15/2011

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

Signature of Applicant 4 / 14 / 11 (Month / Day / Year)

(Continued on page5)

NATIONAL PROVIDER IDENTIFIER (NPI)

The primary purpose of the NPI is to uniquely identify health care providers as "health care providers" in HIPAA standard transactions. The NPI will replace all other identifiers assigned to health care providers, such as those assigned by health plans, government programs and health care purchasers for purposes of conducting these business transactions. Under the final HIPAA NPI Rule, all individual and organization covered providers **were required to obtain an NPI by May 23, 2007.**

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

My current NPI is: 1932385978

Penalties for Falsifying Information on the National Provider Identifier Application

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

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

Signature: _____ Date: 4/14/11

General CV
Updated 4/2011

Kathryn Johnson Gray

EDUCATION

7/2007 - 6/2011	**Emory University**, Atlanta GA Residency in Gynecology and Obstetrics, completion date, June 2011
6/1999 - 5/2007	**University of Michigan Medical School**, Ann Arbor, MI Medical Scientist Training Program MD/PhD in Immunology, awarded May 2007 Leave of absence for PhD from MD program was 6/2001 – 8/2005
8/1995 – 5/1999	**University of Wisconsin-Madison**, Madison, WI B.S. in Biochemistry, awarded May 1999

RESEARCH

2008-present	Robert N. Taylor, MD, PhD, Emory University **Effect of alcohol on placental angiogenesis**
2000-2005	Gary D. Glick, PhD, University of Michigan **Elucidation of the target and molecular mechanism of action of the immunomodulatory benzodiazepine, Bz-423**
1997-1999	Laura L. Kiessling, PhD, University of Wisconsin-Madison **Synthesis of glycomimetic libraries for targeting C-type lectins**

HONORS AND AWARDS

- 43rd Annual John D. Thompson Resident Research Day, 1st prize, 2009
- CREOG Honor Role, 2008-2010
- Golden Apple award for Excellence in Teaching, 2008-2010
- J. Robert Willson Award for Outstanding Achievements in Obstetrics & Gynecology, 2007
- Alpha Omega Alpha member, inducted 2006
- Michigan Teaching Fellow Certificate, Preparing Future Faculty Seminar, 2004
- Medstart President's Award, for dedication to child advocacy, 2003
- Galens Medical Society Blue Tag Award, for outstanding service during Tag Days, 2002
- Mary Shine Peterson Biochemistry Scholarship recipient, 1998-1999
- Golden Key National Honor Society, 1998-1999
- Wisconsin Academic Excellence Scholarship recipient, 1995-1999
- Education Fellows Program fellow, 1995-1997

General CV
Updated 4/2011

EMPLOYMENT EXPERIENCE

2004-2005	**Editorial assistant**, Immunology Department, University of Michigan
2003	**Tutor**, USMLE Step I, University of Michigan Medical School
2002	**Teaching assistant**, Molecular & Cellular Biology, University of Michigan
2000-2001	**Scribe**, Phi Chi Note Service, University of Michigan Medical School
1998-1999	**Tutor**, TRIO Student Support Services, University of Wisconsin-Madison
1997-1998	**Office assistant**, Clinical Trials Unit, University of Wisconsin Hospital & Clinics
1997	**Industrial laborer**, West Bend Company, West Bend, WI
1996	**Economic support mentor**, Department of Social Services, West Bend, WI
1991-1996	**Piano accompanist/choir director**, 5th Ave United Methodist, West Bend, WI

VOLUNTEER EXPERIENCE

- **Medstart Child Advocacy Group**, 1999-2007
- **Galens Medical Society**, 1999-2007
- **MSTP Program Activities Committee**, Chair, 2003-2005
- **Graduate Student Council**, Department representative, 2003-2005
- **Summer Undergraduate Research Program**, Mentor, 2003
- **Curriculum Review Committee**, MSTP student representative, 2001
- **American Medical Women's Association**, Executive board member, 1999-2001
- **Students Teaching AIDS to Students**, Program instructor, 1999-2001
- **Adolescent Substance Abuse Program**, Program instructor, 1999-2001
- **Appalachian Service Project**, Volunteer, 1991-1996

PUBLICATIONS

- **Johnson K.M.**, Swenson L, Opipari AW Jr, Reuter R, Zarrabi N, Fierke CA, Börsch M, Glick GD. (2009) Mechanistic basis for differential inhibition of the F(1)F(o)-ATPase by aurovertin. Biopolymers. 91(10): 830-840.
- Cleary, J., **Johnson, K.M.**, Opipari, A.W., Jr., and Glick, G.D. (2007) Inhibition of the mitochondrial F_1F_0-ATPase by ligands of the peripheral benzodiazepine receptor. Bioorg Med Chem Lett. 17(6):1667-70.
- **Johnson, K.M.**, Cleary, J., Fierke, C.A., and Glick, G.D. (2006) Mechanistic basis for therapeutic targeting of the mitochondrial ATPase. ACS Chemical Biology 1(5): 304-308.
- **Johnson, K.M.**, Chen, X., Boitano, A., Swenson, L., Opipari, A.W., Jr., and Glick, G.D. (2005). Identification and validation of the mitochondrial F_1F_0-ATPase as the molecular target of the immunomodulatory benzodiazepine Bz-423. Chemistry & Biology 12: 485-496.
- Schuster, M.C., Mann, D.A., Buchholz, T.J., **Johnson, K.M.**, Thomas, W.D., Kiessling, L.L (2003). Parallel Synthesis of Glycomimetic Libraries: Targeting a C-Type Lectin. Organic Letters 5(9): 1407-1410.
- Blatt, N.B., Bednarski, J.J., Warner, R.E., Leonetti, F., **Johnson, K.M.**, Boitano, A., Yung, R., Richardson, B.C., Johnson, K.J., Ellman, J.A., Opipari, A.W., Jr., and Glick, G.D. (2002). Benzodiazepine-induced superoxide signals B cell apoptosis: mechanistic insight and potential therapeutic utility. Journal of Clinical Investigation 110: 1123-1132.

INTERESTS

Camping, biking, hiking, sewing, playing piano / guitar, cooking

SUPPLEMENT FORM

PRINT NAME: Kathryn Johnson Gray DATE: 4/14/11

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

QUESTIONS	YES	NO
1. Since your enrollment in college, have you been subject to any disciplinary action (see definition) at an academic institution?		
2-A. Have you ever been terminated or granted a leave of absence by a medical school or any postgraduate training program or have you ever withdrawn from a medical school or any postgraduate training program or had to repeat a year of postgraduate training?		
2-B. Have you ever, for any reason, been placed on probation by a medical school or any postgraduate training program?		
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: Kathryn Johnson Groendyke, Kathryn Marie Johnson		
4. Since your enrollment in college, have you been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination?		
5. Have you ever failed any of the following examinations: FLEX, any State Board examination, any part of the National Boards, any Step of the USMLE, NBOME, or have you failed to gain certification from the National Board of Medical Examiners, any other certification body or any foreign licensing or certification body?		
6-A. Have you ever, for any reason, been denied a medical license, whether full, limited, temporary, or have you withdrawn an application for medical licensure?		
6-B. Have you ever voluntarily surrendered a license to practice medicine or any healing art?		
7. Have you ever, for any reason, lost American Board of Medical Specialty or been denied required recertification by one or more specialty boards?		
8-A. Are any formal disciplinary charges pending against you, or do you have knowledge of any pending investigation into your professional competence or conduct by any governmental authority, health care facility, group practice or professional medical society or association (international, national, state or local)? (See definition).		
8-B. Has any disciplinary action ever been taken against you for violation of laws, rules, by-laws, or standards of practice by any governmental authority, healthcare facility, group or professional medical society or association (national, state or local)?		

Applicant's Signature: _____ Date: 4/14/11

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

Applicant's Signature: _____ **Date:** 4 /14 /11

Revised: 12.01.10

LOA Ltr.

Full License Application

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

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

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

Applicant's Signature: _____ Date of Birth _____

Print or Type Name: Gray (Last name), Kathryn (First Name) Johnson (Middle Initial) Social Security No: _____

Other Name(s) (Please type or print name(s)) Kathryn Johnson Groendyke, Kathryn Marie Johnson

Name of Medical School: University of Michigan Medical School

Address: 1301 Catherine Rd City: Ann Arbor State or Province: Michigan 48109

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

_____

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: Univ. of Wisconsin-Madison BS 05/99

Undergraduate School Address: Madison, WI

(Continued on page 2)

Enrollment and Participation: Our records indicate that

(type or print the applicant's name): Geay (Last name) Kathryn (First name) J (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	8/17/99	5/15/00	5/8/06	4/1/07
	8/14/00	6/22/01	/ /	/ /
	5/2/05	4/30/06	/ /	/ /

The applicant attended 104 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☒ was awarded a degree in Doctor of Medicine on (month/day/year) 5/11/2007

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

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

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

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

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Susan K Hayward

Print Name: Susan K. HayWard

Title: Registrar

Date: 5/13/11 Telephone: (734) 936-1476

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

Seal Verified

DATE: 5/11

INITIALS: WB

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

MEDICAL EDUCATION VERIFICATION

APPLICANT INSTRUCTIONS: Please complete the waiver for release of information and forward this form to your university/medical school(s) or university of graduation for verification.

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

Applicant's Signature: _____ Date of Birth: _____

Print or Type Name: Gray (Last name), Kathryn (First Name) Johnson (Middle Initial) Social Security No: _____

Other Name(s) (Please type or print name(s)): Kathryn Johnson Groendyke, Kathryn Marie Johnson

Name of Medical School: University of Michigan Medical School

Address: 1301 Catherine Rd City: Ann Arbor State or Province: Michigan 48109

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

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

APPLICANT'S EDUCATIONAL HISTORY

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

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

If "yes," indicate where the applicant completed premedical school.

Applicant's Undergraduate School: B.A. from Univ of Wisconsin

Undergraduate School Address: Madison, WI

(Continued on page 2)

Full License Application

Enrollment and Participation: Our records indicate that Kathryn J Groendyke
(type or print the applicant's name): (Last name) (First name) (Middle initial)

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

ATTENDANCE DATES:	FROM	TO	FROM	TO
	08/17/1999	05/15/2000	05/08/2006	04/01/2007
	08/14/2000	06/22/2001	/ /	/ /
	05/02/2005	04/30/2006	/ /	/ /

The applicant attended 164 total weeks or _____ total months (must be included) of not less than 32 weeks in each academic year of continuing on-campus education.

check one ☑ was awarded a degree in Doctor of Medicine with Distinction in Research on (month/day/year) 05/11/2007

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

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

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

COMMENTS: _____

AFFIX INSTITUTIONAL SEAL HERE

(If the institution does not have a seal, this form must be notarized) INTERNATIONAL MEDICAL SCHOOLS MUST ATTACH A COPY OF THE MEDICAL SCHOOL DIPLOMA AND A TRANSCRIPT OR PROVIDE AN EXPLANATION.

Signature: Paul Robinson
Print Name: Paul Robinson
Title: University Registrar
Date: 05/10/2011 Telephone: (734) 763-9066

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

Seal Verified
DATE: 5/11
INITIALS: WS

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/7/2011

Print or Type Name: Kathryn Johnson Gray (former: Kathryn Johnson Groenelyke)

Name of Institution: Emory University Department of Gynecology + Obstetrics

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Emory University Department of Gynecology + Obstetrics If name of institution was different when applicant attended, please enter name: _____

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

(List each year separately with from and to dates)

Program Type (internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RRC, AOA or not accredited
Internship	1	GYN/OB	07/01/2007	06/30/2008	Yes	Yes
Residency	2	GYN/OB	07/01/2008	06/30/2009	Yes	Yes
Residency	3	GYN/OB	07/01/2009	06/30/2010	Yes	Yes
Residency	4	GYN/OB	07/01/2010	06/30/2011	Yes	Yes

(Continued on page 2)

APPLICANT'S NAME: Gray, Kathryn Johnson

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Carla Roberts MD PhD

Print Name: Carla Roberts MD PhD

Academic Title: Residency Program Director

Telephone: (404) 251-8800 Today's Date: 03 / 07 / 2011

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

Notary Public, DeKalb County, Georgia
My Commission Expires Dec. 8, 2014
Melanie S. McGraw

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/7/2011

Print or Type Name: Kathryn Johnson Gray (former: Kathryn Johnson Groendyke)

Name of Institution: Emory University Department of Gynecology + Obstetrics

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Name of Institution: Emory University Department of Gynecology + Obstetrics If name of Institution was different when applicant attended, please enter name: _____

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

(List each year separately with from and to dates)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	4	GYN/OB	07/01/2007	06/30/2011 (Will complete in 6/11)	X	

(Continued on page 2)

APPLICANT'S NAME: Gray, Kathryn Johnson

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: C Roberts MD PhD

Print Name: Carla Roberts MD PhD

Academic Title: Residency Program Director

Telephone: (404) 251-8800 Today's Date: 03 / 07 / 2011

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

Notary Public, DeKalb County, Georgia
My Commission Expires Dec. 8, 2014

Milanne S. Tunkara

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

MALPRACTICE HISTORY

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

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

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

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

Liability Carrier: Clifton Casualty Insurance From: 07 /2007 To: 07 / 2011
City: Atlanta State: GA Policy Number: 1-00061-HE 2011

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

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

Applicant's signature: _____ 4 / 14 / 11
Date

Print Name: Kathryn Johnson Gray (former: Kathryn Johnson Groendyke)

Address: _____ City: _____

State: _____ Zip code: _____

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

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

MALPRACTICE HISTORY

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

Waiver for Release of Information

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

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

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

Liability Carrier: Clifton Casualty Insurance From: 07 /2007 To: 07 / 2011
City: Atlanta State: GA Policy Number: 1-00001-HE 2011

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

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

Applicant's signature: _____ 4 / 14 / 11 Date

Print Name: Kathryn Johnson Gray (former: Kathryn Johnson Groendyke)

Address: _____ City: _____

State: _____ Zip code: _____

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

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/7/2011

Print or Type Name: Kathryn Johnson Gray (former: Kathryn Johnson Groendyke)

Name of Institution: Emory University Department of Gynecology + Obstetrics

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a **sealed envelope, signed across the seal**. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Emory University Department of Gynecology + Obstetrics If name of institution was different when applicant attended, please enter name: _____

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

(List each year separately with from and to dates)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Residency	4	GYN/OB	07/01/2007	06/30/2011 (Will complete in 6/11)		X

(Continued on page 2)

APPLICANT'S NAME: Gray, Kathryn Johnson

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. **If you answer yes to any of these questions, please enclose an explanation.**

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: C Roberts MD PhD

Print Name: Carla Roberts MD PhD

Academic Title: Residency Program Director

Telephone: (404) 251-8800 Today's Date: 03 / 07 / 2011

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

Notary Public, DeKalb County, Georgia
My Commission Expires Dec. 8, 2014
Milissa S. Tomlinson

PRINT NAME: Gray, Kathryn Johnson

Pre-medical School

Facility: University of Wisconsin- Madison Degree: BS From 08/29/1995, To 5/18/1999
Street: 333 East Campus Mall #10101 City: Madison State: WI 53715

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

Medical School

Facility: University of Michigan Degree: MD, PhD From 07/01/1999, To 5/11/2007
Street: 1301 Catherine Rd City: Ann Arbor State: MI 48109

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

Date of medical school graduation: 05 / 11 / 2007
Month Day Year

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

Postgraduate Education:

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

From To

Facility: Emory University Ob/Gyn Dept Position: PGY1-4, 07/01/07, 06/30/11
Street: 69 Jesse Hill Jr Dr SE City: Atlanta State: GA 30303

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

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

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

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

PRINT NAME: Gray, Kathryn Johnson

Hospital Affiliations and Employment

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

		From	To
Facility: n/a Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		
Facility: Position:		__/__/__	__/__/__
Street: City:	State:		

1. List other states (abbreviations) where you are currently or have ever had a full license: n/a
2. a) Are you certified by the American Board of Medical Specialties? ☐ Yes ☒ No
   b) Are you certified by the American Board of Osteopathic Medicine? ☐ Yes ☒ No
3. List Board Certification(s): n/a Certification date: __/__/__
   Certification date: __/__/__
4. List your practice specialt(ies) n/a
5. Have you attached an up-to-date copy of your curriculum vitae? ☒ Yes ☐ No
6. Reason for requesting a Massachusetts medical license: Plan to practice in Boston starting as early as 07/2011; will start fellowship in MFM-Genetics at Brigham+Women's 7/2012
7. Name of Facility: Brigham and Women's Hospital
   Address: 75 Francis St City: Boston MA 02215-1213
8. Anticipated starting date in Massachusetts: 07/15/2011

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

Signature of Applicant

4 / 14 / 11
Month Day Year

(Continued on page5)

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

POSTGRADUATE TRAINING VERIFICATION

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

Applicant's Signature: _____ Date: 3/7/2011

Print or Type Name: Kathryn Johnson Gray (former: Kathryn Johnson Greenabyke)

Name of Institution: Emory University Department of Gynecology + Obstetrics

INSTRUCTIONS TO THE PROGRAM DIRECTOR

Please complete this form and forward it to the applicant in a sealed envelope, signed across the seal. If the department was a "rotating" or "transitional" program, please submit documentation of the rotations, dates and hours of training.

Name of Institution: Emory University Department of Gynecology + Obstetrics If name of institution was different when applicant attended, please enter name: _____

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

(List each year separately with from and to dates)

Program Type (Internship, residency, fellowship)	PGY (1,2,3,4)	Department or type of specialty training	Dates Attended (MONTH/DAY/YEAR) FROM	TO	Completed (YES/NO)	Accredited By (ACGME, RSC, AOA or not accredited
Internship	1	GYN/OB	07/01/2007	06/30/2008	X	X
Residency	2	GYN/OB	07/01/2008	06/30/2009	X	X
Residency	3	GYN/OB	07/01/2009	06/30/2010	X	X
Residency	4	GYN/OB	07/01/2010	06/30/2011		

(Continued on page 2)

97 07/22/11

POSTGRADUATE VERIFICATION FORM PAGE - 2

APPLICANT'S NAME: Gray, Kathryn Johnson

Unusual Circumstances: The following questions apply to unusual circumstances that occurred during any part of the applicant's medical education. Please circle the appropriate response. If you answer yes to any of these questions, please enclose an explanation.

QUESTIONS	YES	NO
1. Did the applicant take any leaves of absence or breaks from his/her post-graduate training?		
2. Was the applicant ever placed on probation?		
3. Was the applicant ever disciplined or under investigation?		
4. Were any negative reports ever filed by instructors regarding the applicant?		
5. Were any limitations or special requirements imposed on the applicant because of questions of academic incompetence or disciplinary problems?		

6. During the applicant's participation, our postgraduate medical training ☐ was accredited by: ☒ ACGME ☐ Other: _____

COMMENTS: _____

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

AFFIX INSTITUTIONAL SEAL HERE

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

Program Director's Signature: Carla Roberts MD PhD

Print Name: Carla Roberts MD PhD

Academic Title: Residency Program Director

Telephone: (404) 251-6800 Today's Date: 03 / 07 / 2011

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

Notary Public, DeKalb County, Georgia
My Commission Expires Dec. 6, 2014

Milena S. Tomlinson

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

Current Status: Active **License Expiration Date:** 6/30/2012

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:
75 Francis St
Brigham & Women's Hospital, MFM
Boston
Massachusetts - 02115
United States of America
(617) 732-4840

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
		None Reported	

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	Obstetrics & Gynecology Dept

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 2 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	03/14/2012	12/31/2012	Claims made with tail coverage

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

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

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

Compliance with Legal Responsibilities

Online profile:

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

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D.

License No.: 248135

Current Status: Active

License Expiration Date: 6/30/2014

1) **Activity Status:** Active

2) **Address & Contact Information**

Mailing Address:

Home Address:

Business Address:

75 Francis St
Brigham & Women's Hospital, MFM
Boston
Massachusetts - 02115
United States of America
(617) 732-4840

3) **Email Address:**

4) **Fax Number:**

5) **Specialties**
Genetics
Obstetrics and Gynecology

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

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

7) **Drug License Numbers**

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) **Other states where you are now licensed to practice**
None Reported

9) **States where you were previously licensed**
None Reported

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

WorkSite	Location
Brigham & Women's Hospital	Obstetrics & Gynecology Dept

Children's Hospital Boston Medical Genetics

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 8 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2014	12/31/2014	Claims made with tail coverage

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

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

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

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

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

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

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

5) I understand and agree to comply with my obligations to report the treatment of victims of rape or sexual assault pursuant to M.G.L. c. 112 sec. 12A 1/2 and I understand the punishment for failure to comply.

6) I understand and agree to comply with my obligations to report a physician to the Board of Medicine pursuant to M.G.L. c. 112 sec. 5F, when I have a reasonable basis to believe that a person violated any provisions of M.G.L. c. 112 sec. 5 or any Board regulation.

7) I understand and agree to comply with my obligations related to charging and collecting fees from Medicare beneficiaries in accordance with the Medicare fee schedule, pursuant to M.G.L. c. 112 sec. 2.

8) I understand and have complied with my obligations to file Massachusetts tax returns and to pay Massachusetts taxes and I understand that, pursuant to M.G.L. c. 62C sec. 49A, my license shall not be issued or renewed unless I make this certification under penalties of perjury.

9) I understand and agree to comply with my obligations related to the reporting of the wages of employees and contractors pursuant to M.G.L. c. 62E Sec. 2.

10) I understand and agree to comply with my obligations related to the withholding and remitting of child support payments pursuant to M.G.L. c. 119A.

11) I understand and agree to comply with my obligations to file an Incident Report with the Board when certain adverse events occur in my private office, pursuant to M.G.L c. 112 sec. 5 and 243 CMR 3.00 et seq. and I understand that the Patient Care Assessment (PCA) programs at the health care facilities where I practice report certain Major Incidents to the Board.

12) I understand and agree to comply with my obligations to disclose ownership interest in any partnership, corporation, firm or other legal entity to which I have referred a patient for physical therapy services, pursuant to M.G.L c. 112 sec. 12AA.

13) I am aware of my obligations and responsibilities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the requirement that I obtain and provide to the Board a National Provider Identifier (NPI) number.

14) I understand and am in compliance with HIPAA and all other federal and state obligations placed upon me as a physician.

15) I understand that as an applicant for a license renewal to practice medicine a criminal record check may be conducted for conviction and pending criminal case information only from the Criminal History Systems Board and that it will not necessarily disqualify me.

[X] **I have reviewed the above statements and certify that I understand my requirement to comply with the responsibilities and obligations of each and agree to do so.**

[X] **Under penalties of perjury, I declare that I have examined this renewal application and all of its accompanying instructions, forms and statements, and to the best of my knowledge and belief, I certify that the information contained herein is true, accurate, and complete.**

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

Current Status: Active **License Expiration Date:** 6/30/2016

1) Activity Status: Active

2) Address & Contact Information

Mailing Address:

Home Address:

Business Address:
75 Francis St
Brigham & Women's Hospital, MFM
Boston
Massachusetts - 02115
United States of America
(617) 732-4840

3) Email Address:

4) Fax Number:

5) Specialties
Genetics
Maternal and Fetal Medicine
Obstetrics and Gynecology

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

ABMS/AOA	Board Name	Certification	Subspecialty
ABMS	Medical Genetics	Clinical Genetics (M.D.)	
ABMS	Obstetrics & Gynecology	Obstetrics and Gynecology	

7) Drug License Numbers

Massachusetts	Federal (DEA)	Federal (DEA) XS

8) Other states where you are now licensed to practice
None Reported

9) States where you were previously licensed
None Reported

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

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

WorkSite	Location
Brigham & Women's Hospital	Obstetrics & Gynecology Dept
Newton-Wellesley Hospital	Maternal-Fetal Medicine

11) Care of patients in Massachusetts
Average weekly hours involved in: **a) inpatient care** 12 hrs/wk
b) outpatient care 8 hrs/wk

12) Medical Liability Insurance Information

Insurance Carrier	Policy Start Date	Policy End Date	Policy Type
CRICO	01/01/2016	12/31/2016	Claims made with tail coverage

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

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

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

16) Other Civil Lawsuits
Question 16 refers to claims or actions related to your competency to practice medicine or your professional conduct in the practice of medicine.
a) New: Have there been any claims, other than medical malpractice claims, filed against you during this time period?
b) Resolved: Have you resolved, settled or adjudicated any lawsuits, other than medical malpractice claims, during this period?

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

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

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

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

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

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

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

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

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

26) Requirement to Complete Training in Recognizing and Reporting Child Abuse
Have you completed training to recognize and report suspected child abuse or neglect?

Commonwealth of Massachusetts
Board of Registration in Medicine
Physician Renewal Application

Physician Name: Kathryn J Gray, M.D. **License No.:** 248135

Compliance with Legal Responsibilities

Online profile:
[X] I have reviewed my Physician Profile and confirm that the information is accurate.

1) I understand and agree to comply with my obligations to report abuse or neglect of children pursuant to M.G.L. c. 119 sec. 51A and I understand the punishment for failure to comply.

2) I understand and agree to comply with my obligations to report abuse or neglect of disabled persons pursuant to M.G.L. c. 19C sec. 10 and I understand the punishment for failure to comply.

3) I understand and agree to comply with my obligations to report abuse, neglect or Financial exploitation of elderly persons pursuant to M.G.L. c. 19A sec. 15 and I understand the punishment for failure to comply.

4) I understand and agree to comply with my obligations to report the treatment of wounds, burns and other injuries pursuant to M.G.L. c. 112 sec. 12A and I understand the punishment for failure to comply.

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